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Problems Met by Hospitals in Compensation Cases

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A COMPLETE discussion of workmen's compensation and its relation to hospitals must necessarily take into consideration the dual rôle exercised by the hospital, first, in its capacity as an employer and second, as an agency of professional service for others. Before entering into a discussion of this relationship, it might be well to give a brief outline of the compensation act in North Carolina.

The North Carolina Workmen's Compensation Act applies to all employers, corporate or otherwise, who have five or more employees regularly in service but excludes from the provisions of the act all casual employees, farm laborers, domestic servants, employees of the Federal Government in North Carolina, state and county prisoners, railroad employees and also persons, firms or corporations engaged in selling agricultural products for the producers thereof.

Since hospitals, in their capacity as employers, are not excluded from the provisions of the act, it follows that application of the act to the hospital is similar to that of any other business, whose status brings it within the terms of the act, notwithstanding the fact that hospitals over the entire country, long before the advent of the first workmen's compensation act in the United States, had always provided gratuitously the best of medical and hospital care for their sick and injured employees. This example, unfortunately, was not generally followed by other business. If such had been the case, there might have been no necessity for the passage of a workmen's compensation act. It must not be construed from the remarks that hospitals desire or would seek exclusion from these acts. On the contrary, the foregoing statements are made only to show that the principles and purposes of the workmen's compensation act, to some extent at least, were practiced generally by the hospitals long before the passage of the first compensation act.

The primary purpose of the North Carolina Workmen's Compensation Act is to guarantee to injured employees or their dependents specific payments of compensation for those accidents, fatal or otherwise, arising out of and in the course of their employment, and, in addition, medical and surgical attention, hospital care, medical and surgical supplies and necessary artificial members, for a period not to exceed ten weeks. This period, however, may in certain cases be extended by the industrial commission at their discretion. An exception is made, however, if the injury or death of an employee is occasioned through his intoxication or by the willful intention of the employee to injure or kill himself or another, in which event, no compensation is payable.

All the costs in connection with these accidents

are in the initial instance guaranteed by the employer, who insures against this risk and in turn adds the cost of this coverage to the sale value of his product or service. So after all the general public has to pay the bill.

The administration of the act is vested in a commission of three members appointed by the governor. This commission is empowered to make all necessary rules and regulations consistent with the act for carrying out the provisions contained therein.

Why Cooperation Is Needed

Some idea of the far-reaching importance of this act and the numerous individuals and institutions in North Carolina that are in some degree directly affected by its provisions will be noted from the following statistics: Approximately 11,500 employers, 900,000 employees, 109 general hospitals and 2,100 physicians come within the jurisdiction of the act. Considering therefore the complexity of viewpoints that naturally confront the commission from time to time in the administration of the act, it behooves the individual persons interested to pull together to the end that such deficiencies as exist in the present act may with mutual satisfaction to all concerned be amended or adjusted by legislative action or otherwise.

The North Carolina Workmen's Compensation Act has been in effect now for nearly two years and in the main has proved acceptable to employers and employees alike. However, as is common with all new laws, time has shown that several sections of the act could have been improved upon advantageously to all concerned and this includes the hospitals. These sections will be referred to later in this discussion.

As the first part of this subject centers around the hospital in the capacity of an employer, a discussion of Sections 25 and 26 of the act will be taken up first. The parts of the sections referred to read as follows:

"Sec. 25. Medical, surgical, hospital and other treatment, including medical and surgical supplies as may reasonably be required, for a period not exceeding ten weeks from date of injury, to effect a cure or give relief and for such additional time as in the judgment of the commission will tend to lessen the period of compensation disability, and in addition thereto such original artificial members, as may be reasonably necessary at the end of the healing period shall be provided by the employer."

"Sec. 26. The pecuniary liability of the employer for medical, surgical, hospital service or other treatment required, when ordered by the commission, shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person."

As the standard of living of the injured party will govern his accommodation in the hospital, that is, whether it shall be private room or ward, who shall decide—the employer, the employee, the doctor or the hospital—as to this standard?

In my opinion the responsibility for this decision should rest on the shoulders of either the employer or the doctor or both jointly, but not on the hospital, because the employer, under the terms of the act, is the one who is required to provide this service and because he is in a better position than anyone else to determine the respective standards of living of his employees. The doctor, on the other hand, should decide whether the patient's condition demands the privacy of a room or not. The only function of the hospital in this connection should be to render the service requested as expeditiously and efficiently as possible.

By what measuring rod shall these standards be gauged?

Rule 18 of the commission reads, in part, as follows:

"The fees of physician, hospitals and attorneys must be reasonable and measured according to the employee's station. The station of the injured person is not to be determined by his or her social status, but by the wages received."

If this rule is strictly adhered to by the commission it will in my opinion operate unfairly on certain individuals and groups of individuals. Take, for instance, the college men, who are employed during the summer vacations; the sons of families in good circumstances, who may be serving apprenticeships at small wages and in some instances for no wages; the thrifty laborer, who has through economy and saving accumulated a substantial sum for a rainy day; the family with independent income over and above the weekly or monthly wage, and last but not least the large group of student nurses in the hospitals, receiving an average allowance of $10 to $15 per month.

The Nurse and Compensation Care

Does it follow that any of these young women in the last mentioned group, who may be unfortunate enough to suffer injury, necessitating hospitalization, will be required to accept ward accommodation, simply because of the small money allowance made by the hospitals, when in reality the standard of living enjoyed by them in the majority of hospitals and nurses' homes is such as to entitle them to the privacy of a room?

And there is the further reason that hospitals generally in North Carolina had for years prior to the passage of the act afforded their nurses private rooms, based in many instances on an implied contract of service between the hospital as an employer and the nurse as an employee. Insofar as the hospitalization of institutional nurses is concerned, private room service is in my opinion the reasonable measure of service required from the employer, as outlined in the first paragraph of Section 25 of the act.

Hospitals as Institutions of Service

Let us now discuss a few sections of the act in their relation to the hospitals as institutions of service. Probably no section of the act has caused as much comment, or brought forth as much adverse criticism from the hospitals as Section 64 (b) of the act, which follows:

"Sec. 64. (a) Fees for attorneys and physicians and charges of hospitals for services under this act shall be subject to the approval of the commission; but no physician shall be entitled to collect fees from an employer or insurance carrier until he has made the reports required by the industrial commission in connection with the case.

(b) Any person (1) who receives any fee, other consideration, or any gratuity on account of services so rendered, unless such consideration or gratuity is approved by the commission or such court, or (2) who makes it a business to solicit employment for a lawyer or for himself in respect of any claim or award for compensation, shall be guilty of a misdemeanor, and upon conviction thereof shall for each offense be punished by a fine of not more than $500 or by imprisonment not to exceed one year, or by both such fine and imprisonment."

The first division of this section pertains among other things to the charges of hospitals for services rendered and while the second division, which is the section under criticism, no doubt was intended to protect the patient and the employer from demands made by unscrupulous hospitals, if such there be, it failed to take into account the much greater number of hospitals whose ethical concept of duty to their patients would preclude the possibility of permitting any such practices as intimated in the section referred to.

In order that the protests of the hospitals to this section may be better understood, I shall give an example of one case in question.

A patient who is to receive compensation is admitted to the hospital and upon instructions of the employer and attending physician is assigned to the open ward. The patient himself, his family or his friends, demand that he be transferred to a private room. The hospital officials explain that under the terms of the compensation act the charges for private room service, in their opinion, will not be allowed. The patient or his relatives then state that if the insurance company will not pay for private room service, then they will be willing to pay the difference between the charges for the ward and private room. The terms of the act do not prohibit the patient from following this procedure, but it has been ruled by the industrial commission that these same terms do prohibit the hospital from concurring with it without the permission of the commission under the penalty aforementioned, which as will be noted is sufficiently severe to deter even the most venturesome.

The hospitals contend, first, that they cannot in all fairness refuse to provide a service that any patient is willing to pay for, provided the service desired is available and is approved by the attending surgeon; second, that they cannot legally compel an injured patient to accept accommodations that he does not desire; third, that if a patient wishes to make a separate voluntary arrangement with a hospital for any extra service over and above that which he would ordinarily be entitled to in conformity with the provisions outlined in Section 26 of the act, then it appears to be a personal matter between the hospital and the patient and outside the jurisdiction of the act and those charged with the responsibility of its administration. This is the frank opinion of a layman, who admits, however, that he is not a lawyer.

Since more disputes, more hearings, more hard feelings, more waste of time, more shifting of responsibility and more delay in the settlement of hospital bills have been occasioned through the divergent interpretations of Sections 25 and 26, I feel that a further discussion of these sections is necessary. It will be recalled that the relation of these two sections to the hospital as an employer has already been discussed. Let us now consider them from the standpoint of the hospital as an agency of public service.

What the Employer Must Provide

Under these sections, the employer is required to provide medical, surgical, hospital and other treatment, including medical and surgical supplies, as may reasonably be required. The pecuniary liability of the employer for these services is limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living, when such treatment is paid for by the injured person.

There appears to be no room for misinterpretation or disputes to arise in regard to the intent

of the law as outlined in these two sections, but unfortunately for the hospitals, some insurance companies have found sufficient grounds for argument, more particularly in regard to the service charges of hospitals, which they contend are too high, but which to the best of my knowledge and belief are no higher than and probably not as high as they were prior to the passage of the State Workmen's Compensation Act in March, 1929.

Should the Hospital Discriminate?

In my opinion, the North Carolina Workmen's Compensation Act did not contemplate that the hospitals of the state should assume additional financial burdens on their already overloaded shoulders by accepting cut rates from the insurance companies for the care of industrial accident cases.

If I understand the theory of workmen's compensation correctly, it is that the injured employee shall not be pauperized and that the full cost of industrial accidents shall be borne in the initial instance by industry. Therefore the classification of these patients in the hospitals should be similar to that of any other private patient who would be required to pay the fees in effect in the particular institution where he was a patient. Why then should the hospitals be required to discriminate in the matter of charges between the industrial accident case and any other of their private patients?

The majority of hospitals are waging a continual battle against annual deficits, particularly the public nonprofit institutions. Have these hospitals then the right, morally or legally, to divert funds appropriated or donated for the care of the indigent sick to help take care of a deficit to which the care of these compensation cases has contributed? I contend that they positively have not. If, on the other hand, the doctor operating his own private hospital desires to contribute part of his professional fees for this purpose, then that is his personal business but in my opinion it is poor business.

Putting the Cards on the Table

The hospitals are striving to render an efficient service at a reasonable cost. They should be encouraged to continue this policy, not hindered. The hospitals are quite willing to lay their cards on the table face up. Let those who would accuse them of being robbers do likewise.

I maintain the further belief that the compensation act did not intend that hospitals should be left in a state of uncertainty regarding the payment of their just bills. Why is it that the insurance companies, in the majority of cases, wait until all the services have been rendered and the patient discharged, before starting an argument about charges, such an argument usually resulting in a hearing before the commission, with further delay before settlement is received? I feel sure that the hospitals, upon request, would be glad to provide the insurance companies, in advance, with a complete schedule of their charges for private cases.

Why is it that the hospital, whose mission it is to render a particular service for these industrial cases, cannot know definitely in advance what to expect in the way of remuneration for its services? The injured employee has this information in advance and the attending surgeon has this information in advance. How much longer, then, must the hospital hold the bag and continue to trust to luck?[1]

A New Tuberculosis Pavilion in Austria

In 1929 the municipal council of Vienna invited Prof. Julius Tandler, commissioner of health of the city, to submit plans for the addition of a tuberculosis division in the *Stadtischen Krankenhaus,* according to an article by Dr. A. Baumgarten and O. Steiner, municipal engineer, in *Zeitschrift für das Gesamte Krankenhauswesen.*

This tuberculosis pavilion is now complete and the administration organized. The pavilion is situated in a section of the hospital park near the woods and has a capacity of 320 beds, with separate sections for men and women. The sexes are separated by the various auxiliary services which are located in the middle of the building, such as service rooms, the x-ray laboratory, the physiotherapy rooms and the library. The east and west sections are divided into two wings each having five groups of wards in which there are thirty-nine beds in the two lower stories and twenty-three in the two upper ones. The upper sections contain a smaller number of beds, thus providing space for two rest rooms, facing south, and placed one above the other. The ward sections consist of two and six bedrooms all of which face the south and all of them provided with disappearing windows, which provide a maximum of light and ventilation. Besides three sets of staircases, there are two elevators for beds. The cost of the building was 5,000,000 Austrian shillings (a little over $700,000) or about $2,100 a bed.

[1]Read at the joint meeting of the Virginia, North Carolina and South Carolina Hospital Associations, Durham, N. C.

The "Home-Away-From-Home" for Sick Children

By EDWIN HYDE LAMBERT
Boston

A CHILDREN'S hotel! That is the first impression a visitor receives upon entering from the quiet grounds of the New England Hospital for Women and Children, Boston, into the pleasant lobby of the new and recently opened children's building.

Situated upon a hilltop in one of the highest and most healthful parts of metropolitan Boston, the buildings that comprise the Women's and Children's Hospital strike the observer with so strong an impression of scientific modernity, that he must needs look to the tall and stately poplars and elms that line the quiet walks and driveways in order to reassure himself that he is inspecting the oldest hospital of its kind in New England—the selfsame institution in which the first trained nurse in America donned her cap over half a century ago.

It was in 1859 that Dr. Marie E. Zakrzewska came to Boston hoping to establish a hospital for women, managed by women. Only a small clinic was started at that time, but the interest aroused by the work led to the founding of this hospital in 1862, the first patients being received in July of that year. The hospital was incorporated March 12, 1863, the incorporators being Lucy Goddard, Marie E. Zakrzewska and Edna D. Cheney.

The objects of the institution were declared to be: to provide for women medical aid of competent physicians of their own sex; to assist educated women in the practical study of medicine; to train nurses for the care of the sick.

Little, however, remains of the old régime except the trees and the tradition. For all else has kept abreast of the times, readily embracing any advance in equipment and technique advocated through the endeavors of conservative scientific research.

The seventy-bed, fireproof children's building, the newest unit of an institution devoted entirely to the care of women and children, is generally admitted to be a triumph of architectural and technical skill. It is an imposing structure, pleasant and airy, supplied throughout with up-to-date equipment and operated by a staff of white uni-

Breakfast in bed is just one of the many advantages of being sick in the children's building of the New England Hospital for Women and Children. These little boys are occupying a semiprivate room with day and night service and lots to eat.

formed experts, informed on every phase of the medical and hygienic care of children. Constructed at the cost of $300,000, these new quarters for the hospital's tiny patients are functioning as smoothly as though they had been established for years, despite the fact that they have been in operation only since June of last year. All this the visitor learns later, but the primary and strongest impression he feels, and one that remains with him long after he has departed, is of some nurseryland hotel where little travelers may check in and engage a room.

It must, then, be one of those hotels that advertise "all the comforts of home," for nothing could be more homelike, both outside and within, than the atmosphere of this charming place.

The long three-story building of red brick and Indiana limestone is approached by a circular driveway, opening off the main quadrangle which is flanked by the medical and surgical buildings. Passing beneath the shaded portico the visitor enters into a well lighted lobby. The outer door closes, and, as if by some strange magical process, the clock turns backward and he breaths again the warm, fancy-laden air of childhood.

Mother Goose Plays Her Part

The walls are frescoed with colorful designs from the domain of Mother Goose: elflike farmers and farmerettes, fields of yellow grain, toy wagons loaded with apples and pumpkins. The chairs and tables suggest a hotel lobby in miniature, and there opposite is the desk behind which sits a smiling "clerk," ready to open the register and surrender the key to a single room with a southern exposure. Where is the frog footman to carry the little guest's

In the main lobby, with its walls frescoed in colorful designs from the domain of Mother Goose and its chairs and tables suggesting a hotel lobby in miniature, a smiling "clerk" receives the "guests." The baby pictured below is being examined in the out-patient department.

bags to the elevator? Surely he must be waiting around the corner.

While the visitor examines all these things, a restful silence, broken only by an occasional sound of children's voices, reigns throughout the building. When he entered from the driveway, all mechanical noise seemed to be left behind. Now he moves across a floor which is apparently tiled, but his feet seem to strike it softly as though he were walking upon a thick pile carpet. The effect is strange, even a trifle weird. It is not until later he learns that the floors are covered with rubber and composition tiles, and that certain of the ceilings are lined with a fiber composition that makes the corridors soundproof.

But where are the children, the guests of this hotel? We might glance into some of the private rooms on the third floor; the elevator is waiting. It is dinner time, and a complicated looking metal wagon, mounted on rubber tired wheels, is being connected to an electric socket in the third-floor diet kitchen. It has just arrived from the hospital's large, centralized kitchen with food specially prepared for this department. Everything is kept hot by means of an electric coil inside the wagon. The food is in insulated compartments.

Here is a good opportunity to follow a tray to

its destination. One of the doors is ajar, and inside can be seen a little dark haired boy of about ten. We are inclined to envy him that comfortable bed with the mauve coverlet, even if he did have to break a leg to get it. But it seems to be causing him little concern. He is reading a magazine and humming to himself. He looks up to find his dinner waiting for him. How time does fly!

Getting Well in Colorful Surroundings

And what a pleasant room to get well in! The individual color scheme is carried out in perfect harmony, from the curtains down to the delicate chintz coverings of the upholstered easy chair. There is a built-in metal wardrobe and equipment cabinet which when closed looks merely like a part of the wall. The furnishing throughout, with the oiled maple chairs and bureau, and the Chippendale mirror, carries a New England air that is at once bright, restful and pleasing.

A look into some of the other rooms reveals that each is decorated in a different color scheme. Some have connecting doors, forming compact double suites with private facilities of every sort. This arrangement makes it possible for mothers who wish to stay in the building to remain for any length of time in close contact with their children.

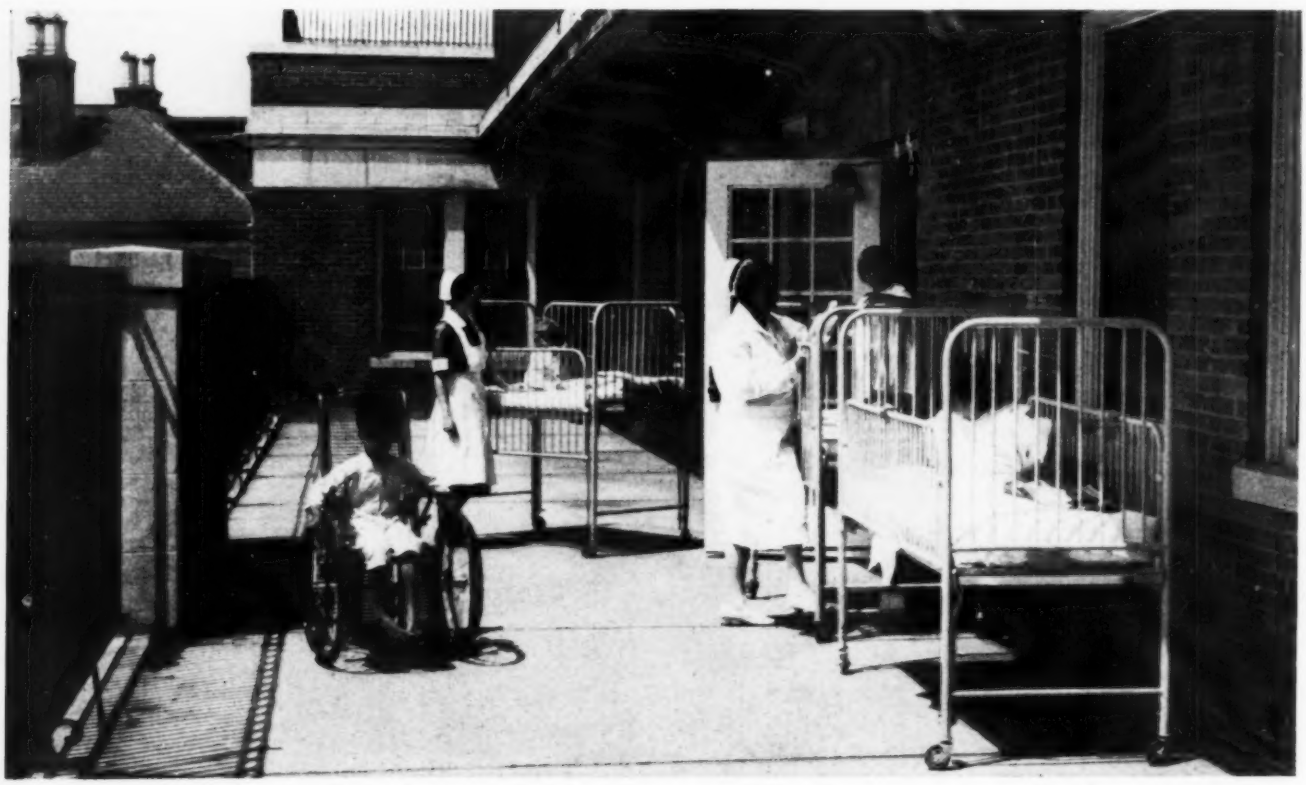
A flood of sunlight and the sound of children laughing attract the visitor's attention to the end of the corridor. A nurse has opened the door of the girls' solarium. Several little girls are engaged in a lively game with a teddy bear and a toy wagon; they seem to find this problem in transportation amusing. While they play, sunshine is streaming in through great windows and filling every corner of the room. It is certainly a glass house, but nobody is in a mood to throw stones.

This sun room is furnished with miniature chairs and tables, and tasteful cretonne curtains. Brightly colored toys and nursery rhyme mural decorations upon the pastel tinted walls complete the picture. The traditional terrors of a hospital are completely lacking.

At the other end of the corridor is a similar sun room for boys. An open sun porch extends the entire length of the building in front and commands a remarkable view of the surrounding country. Lack of sunlight is quite evidently not a problem in the children's building.

Rooms to Suit Every Purse

This hotel provides accommodations "to suit every purse." The third floor has semiprivate as well as private rooms, and the entire second floor is arranged for ward patients, one end being for boys and the other for girls. Here, too, are boys' and girls' sun rooms at opposite ends of the building, in addition to a sun porch on to which the wards open. Many patients—none over fourteen, and the majority much younger—receive as expert



On open porches adjoining the wards the young patients receive their daily dose of sunlight and fresh air.

These children, sick and poor, are waiting with their mothers for admission to the hospital clinic, where free and part-pay care is given.

treatment here for the various ailments of childhood as do their neighbors on the floor above.

Although each ward accommodates six beds, a certain amount of privacy is attained by the use of cubicle partitions, so constructed that no light or air is sacrificed. Electric lights with adjustable shades are above each cot.

On the Highway to Health

Two surgical and two medical wards occupy the greater length of one side of this floor. On the other side are four observation rooms, a dark room for nose, throat and eye examinations, and a consultation room for visiting doctors. The remaining space is occupied by utility rooms equipped with modern sterilizers, supply cupboards and shelves for the storage of linen. The linen is distributed and collected by means of metal wagons mounted on rubber tired wheels.

Apart from the children's quarters, but easily accessible to them, are major and minor operating rooms and their accompanying dressing rooms. The floor nurse's desk is centrally placed between the girls' and the boys' sections, in such a way as to allow for a maximum of supervision.

Cots may be wheeled from the wards out through the large doors that give access to the sun porch. The cots have high sides and move easily on their ample wheels. The children take their toys with them, and chuckle with pleasure at this novel form of locomotion. The visitor is reminded of dreams he had as a child, in which his bed bore him swiftly and smoothly on a fantastic journey through strange lands. For these children the dream has become a reality, and they are enjoying the ride to the utmost.

Out on the porch they can play happily in the sun under the watchful care of their nurses. It is a highway to health, and there are no traffic regulations. Parking is allowed all day long—provided, of course, the sun is shining.

Clinic Service Is Well Planned

To one side of the building, on the first floor, is a door which opens into a long, well lighted passageway. The sides of this passage are lined with benches, and the benches, of a morning, are usually filled to capacity with mothers and children—infants in arms and little boys and girls of varying ages. Their presence in this place can mean but

one thing: they are sick and they are poor, an unfortunate combination. Beyond the glass doors at the end of the hall are the children's clinics, where treatments are either partially paid for or are entirely free.

Excellent eye and orthopedic clinics are already well established in the children's department. In the well baby clinic infants of mothers from the maternity wards and from outside the hospital are carefully examined at regular intervals for early symptoms of infantile disorders. This prophylactic service marks a distinct advance over the older methods of medical science, which concentrated too much upon the cure of disease and too little upon its prevention.

Children from all parts of metropolitan Boston are brought to the New England Hospital for treatment. Of late years the volume of small patients had become so great as to render the old quarters inadequate. Jessie E. Catton, for eight years superintendent of the New England Hospital, has observed in her annual report for 1930, "Probably only the group of workers having had experience with present conditions—which have become a little more difficult each year—can fully appreciate what the new building will bring in the way of proper housing and facilities for the care of sick children." The happy future to which this statement points seems already to have arrived. Last year 1,270 young patients were cared for in the children's department. The new children's building has been in operation not quite a year; yet in this period approximately 2,000 cases have been treated.

It would be superfluous to hold forth upon the needs that brought the children's building into being. Figures such as these speak eloquently enough. Let it suffice to say that the sponsors of the new unit have planned wisely and well, and have laid a foundation of physical and mental health for a generation which shall one day form a small yet representative part of the manhood and womanhood of America.

Is a Lie the Price of a Postmortem Examination?

All recognized hospitals in this country are laudably striving to increase the percentage of examinations of the bodies of patients dying within their wards and rooms. It is difficult to educate the public as to the necessity for such studies. Moreover, there is an understandable repugnance on the part of friends and relatives to the incision of the tissues of the bodies of patients to whom they had been attached.

It should be emphasized in this connection that no postmortem examination should ever be held unless permission for it can be obtained in a perfectly truthful and ethical manner. Deceit and lying should be foreign to the nature of the physician. Hospital authorities and members of the visiting staff while earnestly desiring an increase in autopsy percentages should not fail to remember that to condone a lie on the part of the intern is to work a definite moral damage to this young physician. There are sufficiently successful methods available by the use of which a creditable number of postmortems can be obtained without resorting to deceit. Moreover, it cannot be too forcibly impressed upon all interns that it is far better to lose the most interesting of autopsies than to obtain one under questionable circumstances. It is only by fair dealing with the public that postmortem percentages can be consistently increased.

Lying is both unnecessary and unpardonable as a means of procuring autopsies. Furthermore, it represents an expensive and ineffective method of obtaining postmortem examinations.

Ministering to the Patient's Mental Condition

Two items universally omitted from the books on therapeutics and treatment should be henceforth important parts—music and books, says an editorial in the *Pennsylvania Medical Journal.* The best schools of nursing should have teachers of music and literature as well as professors of surgery and obstetrics. Above all, nurses should be good readers and, if possible, good musicians. Physicians should advise about what books to be read as much as about what drugs to be given and what food to be eaten.

"The patient's mental condition is often quite as important in the proper treatment of disease as is his physical status," the editorial continues. "Failure to realize this fact has doubtless been in the past a professional sin. Our textbooks on therapeutics and materia medica tell us about hundreds of drugs; some of them allude with too vague indifference to hygienic methods of treatment, but how many of them recognize and advise as to the highly important conditions of the patient's will and disposition? Every physician of discernment knows that the mental attitude of the patient governs, often entirely, always to some extent, the morbid processes and the nutritional reactions. The cheerfulness and friendliness of the old-time general practitioner were perhaps needed to neutralize his bad medicines, but they were powerful therapeutic agents."

A Composite Picture of the Modern Hospital and Its Management

By LEWIS N. CLARK
Superintendent, Germantown Dispensary and Hospital, Philadelphia

DR. HOWARD HAGGARD in his book "Devils, Drugs and Doctors," tells us that in the year 1505 the Parliament of Paris nominated a commission of eight citizens to manage the temporal affairs of *l'Hôtel Dieu*. He says: "Whatever the shortcomings in medical practice may have been, there was at least a healthy directness in handling administrative difficulties; the monks and nuns who objected to the changes that were made were dismissed, and the physicians who sided with them were committed to prison."

Past Horrors and Present Progress

How often the management of the hospital of to-day would like to use this kind of "healthy directness." Max Nordau's account of the horrors of *l'Hôtel Dieu* at that time, Semmelweis' description of the Gratz Hospital as recently as 1850, and La Forte's of the *Matérnité* of Paris in 1864, should, however, give us some encouragement when we consider how far we have come and how few are our shortcomings in comparison with the hospitals of seventy-five years ago. I believe that in no line of human endeavor has such progress been made, even though all hospitals, no matter how carefully they are managed, are still the object of more or less frequent criticism.

Everyone who has the responsibility of a hospital is willing to acknowledge that his institution deserves criticism in many instances and that things occur, sometimes too frequently, that are much to be regretted. I am going to try to show later on why it is so difficult to prevent many of these occurrences. One criticism, however, that every hospital man resents as he would an unkind word about his only child is that of extravagance. When I hear someone speak of hospitals "throwing the public's money around" or saying "if they were in regular business they would use business methods and be more careful how they spend their money," I feel a great deal of resentment. There is only one business in any way comparable to hospitals, and that is the hotel business. One often hears a hospital compared to an American plan hotel, usually to the advantage of the hotel. Let us have a look at this comparison and see if the charge of hospital extravagance is justified.

I found it somewhat difficult to get accurate figures on hotel costs. Also, it was necessary that I know what part of their costs is included in such items as interest on investment, taxes and depreciation. Hospitals usually have no interest on investment because the money that builds them is given by the public. Depreciation is rarely figured in the hospitals' operating costs, and they are free of taxes unless privately owned. Two prominent firms of auditors and hotel cost accountants kindly provided me with the figures I needed. One firm gave me a composite figure of $6.70 cost per guest per day. Included in this is $1.75 a day for the three items I have mentioned, leaving a net operating cost of $4.95. They have warned me that these figures are for American plan hotels and that few of them operate twelve months a year, and the costs are consequently higher than they would be if these hotels operated continuously. The other firm compiled figures for me from averages of over 150 hotels of various sizes. They show an average cost per guest per day of $5.75, the items of interest, depreciation and taxes accounting for $1.40 of this, leaving a net operating cost of $4.35 per day. If we strike a mean between these two groups of hotels we arrive at a figure of $4.65 per guest per day, not including the items that I have just mentioned.

What It Costs to Run a Hospital

As to hospital operating costs, Pennsylvania reports for twenty-eight state aided hospitals of 200 beds and over, for the year ending February 28, 1931, an average cost per patient per day of $4.64. This group of large hospitals, including the Germantown Dispensary and Hospital, Philadelphia, is made up of those caring for well-to-do patients in private rooms as well as for ward patients. City hospitals that care for ward patients only and in which the cost is kept down to a minimum are not included. These hospitals give

an American plan hotel service, but they give a great deal in addition, all of which is included in the patient day cost. I am quoting the average for the twenty-eight hospitals. The operation of the pathologic laboratory cost 17 cents per patient day, the x-ray department, 17 cents, the special therapy department, 4 cents, and the social service department, 5 cents. The out-patient department, although it has nothing to do with the in-patient cost, was included in these figures sent out by the state, and cost 11 cents per in-patient day. Ambulance service cost 3 cents, anesthetics cost 8 cents, medical and surgical supplies, 19 cents, drugs, 13 cents, medical services, 8 cents, and nursing, 67 cents. This leaves us $2.92 of our $4.64 per diem cost and we still have one important item to consider before we can make a fair comparison with the hotel figure.

Paying for the Training School

Hospitals not only care for the sick; many of them are training schools for medical students and twenty-seven of the twenty-eight hospitals reporting have training schools for nurses. There is an average of from one to one and a half pupil and graduate nurses to every three patients, and hidden away in the housekeeping, dietary, operation of plant and maintenance and repair items is the cost of the care of the nurses' home and the feeding of the nurses, and again the housing and the feeding of the employees who care for the nurses' quarters and who serve their meals. If we add to this the living expenses of the intern staff and the cost of the laundry for all the nurses and the interns, we have another item of cost, which hotels do not have, of at least 87 cents per patient day. We now have a balance of $2.05 left as compared to the hotel's cost of $4.65 per guest day, and I have not attempted to show the living cost of the dietitians, anesthetists, druggists and other hospital employees who because of the nature of their work must live within the hospital and be kept by the hospital.

I do not believe that this group of hospitals, the cost figures of which I have given, can be charged with either extravagance or inefficient management. It can be taken for granted that their costs are as low as is consistent with the good service they try to give.

I trust that I have satisfactorily met the charge of extravagance in hospital management, and I should like to show that this very low cost figure is partly responsible for the other criticisms that are directed at hospitals. I think it reasonable to assume that in a hotel the room clerk takes care of the room clerk's work and nothing else, and that the cashier limits his duties to those of a cashier, and that the same can be said of the floor clerk.

An entirely different state of affairs exists in the usual hospital. The cashier, instead of giving his undivided attention to the satisfactory settlement of the bill of a patient about to leave, usually has two or three telephones on his desk and at the same time is taking a room reservation from one doctor, an ambulance call from another, and possibly is trying to satisfy all concerned in making an entry on the operating room schedule on the third telephone. Is it any wonder that the friend of the patient who is trying to pay his bill for him grows impatient and leaves the hospital "cussing" it soundly?

The switchboard operator instead of attending to her legitimate business often acts as information clerk, giving news bulletins to the families of very ill patients and sending out word of operations not only to patients' relatives but to the doctors. Recent counts made at my own hospital showed that one telephone operator handled an average of 180 calls between the hours of 12 and 1 p.m., at the same time that she was relieving the information clerk who was at lunch. She answered all inquiries as to the condition of patients, was supposed to locate every one of the twenty-five to fifty doctors somewhere in the plant and to do this immediately, and at the same time was expected to listen courteously to the life story of the sister-in-law of a patient who was supposed to be in the hospital but later on was located at some other hospital. All this had to be done with courtesy and care, or you can be sure the superintendent's office would soon have heard about the hospital's "rotten telephone service."

Too Many Demands Made on Head Nurse

The head nurse on the ward or private floor is head nurse, floor clerk, complaint receiver, newspaper boy and general handy man. She is trained as a nurse and is primarily interested in nursing, one of her principal duties being the training of the pupil nurses at work in her section of the hospital, but because of the ever present financial shortage, she must combine her nursing duties with many other less important ones, sometimes with unsatisfactory results.

Every business man recognizes the need of well trained workers in his organization, workers who have definite jobs to which they are permitted to give their undivided attention. If I were to take a layman through an average hospital and show him the multitude and variety of duties imposed on many of the personnel, he would wonder why more errors are not made.

An additional source of trouble is the training

school for nurses. I have been told many times that it should be easy to keep the cost of operating a hospital at a low figure when the ridiculously low allowance paid the student nurse is taken into consideration. It is true that the average payments to pupils in hospital training schools is not over $10 a month, but the cost of maintaining this large "girls' boarding school" is a considerable item. I have no average figure for a group of hospitals, but in my own the cost is about $580 per pupil per year, which, added to the allowance of $120 per year paid the pupils, brings the cost of this help to nearly $60 per month.

Years ago the pupil nurse scrubbed floors, did general housecleaning and other menial tasks entirely unconnected with the profession of nursing. It is fortunate, for her self-respect and for the self-respect of the institutions, that this is no longer the case. Also, in order to fit these girls properly for the practice of their profession, such a large aggregate number of hours is required in the classroom that during the first year particularly they are not as useful as they might be to the hospital.

Which Is Cheaper—Graduates or Students?

There is much discussion in the hospital world just now as to whether it would be cheaper to operate hospitals by employing graduate nurses only or to continue to operate with the student nurse body under the supervision and direction of graduates. My own opinion is that graduates only would be cheaper. This is a discussion, however, that gets us nowhere since pupils must be trained before there can be graduates, and if a number of the training schools were to close the present oversupply of nurses would soon become an undersupply and the schools would have to open again. It is true that hospitals are now turning out more nurses than can find employment, but I believe that this is a temporary situation due to the financial depression which is causing unemployment in all other lines of work.

A hospital is fulfilling one of its duties to the community in turning out good well trained nurses. It is a great satisfaction to a hospital to do so, but it cannot be said to be an unmixed blessing. The students are constantly in touch with the patients and their families and friends, and since these students when they come to the hospital are just the same as any other group of boarding school girls, the possibilities of trouble in the situation are obvious. These students are, generally speaking, serious-minded and intent on becoming proficient in their profession, but they are young and sometimes tactless, and many of the criticisms of hospitals arise from this fact.

When we consider the exceedingly low cost at which hospitals are operated, a question that naturally arises is why the administrator of the hospital puts up with the state of affairs one so often finds. I believe the answer is that the executive is more at fault (if fault it can be considered) than anyone else. He realizes as well as any of the trustees just how difficult it is to find sufficient money to run a hospital as it should be run.

Suppose he goes to his board and says: "This error that we have committed and that error and the other one are due to the fact that half the people in our employ are trying to do more than it is humanly possible to do; we must spend more money." What will be the answer? Boards are already raising all the money they can. No hospital administrator will recommend cutting down on the free work of the ward and out-patient services unless it is the last remedy he can think of, and if the charges for private rooms and services are increased there will be trouble with the community.

In theory, those who are sick should not be made to pay fancy prices for their misfortune. The wealthy undoubtedly have a right to feel that they give generously to charity and that when they are ill, they should not be made to pay an amount that will show a profit to the hospital. I have often thought that an ideal arrangement would be to make only sufficient profit from the more expensive private service to ensure good care for "the people of moderate means" at a price so low that illness becomes possible for them in a dignified way without the necessity of going into the wards. This would certainly please the people of moderate means and would remove one of the principal causes of criticism to which hospitals are subjected. The wealthy would not object if private accommodations at a wide variety of prices were available for them, from which they could take their choice, and if the total receipts from these variously priced services were sufficient to pay the cost of all of them. This would, of course, leave the hospital holding the bag for its ward and dispensary services, just a little worse off than it is now when a small profit is made from the private services and applied toward the staggering costs occasioned by the free services.

Let's Remember the Doctors' Free Work

The doctors working in a hospital find themselves in much the same situation. They are criticized for sending big bills to their wealthy patients and for charging a handsome sum for a single operation. Does anyone stop to think of the amount

of free service they give the poor and unfortunate, not only in the wards and dispensaries but in their offices and in the patients' homes?

An effort is now being made to evaluate the amount of free work done by the staff of my own hospital in a year's time. The complete figures are not yet available, but it is not difficult to arrive at an approximate figure which will be close to the true one. One hundred thousand visits a year are made to the dispensaries. No doctor that I know of who has good medical education and experience will see patients in his office for a dollar a visit, but since dispensary work is somewhat similar to mass production, we have put this value on each visit the patient pays to the doctor in the dispensary. There are 18,600 patient days each year in the medical wards. The doctor sees these patients every day, but a safe assumption is that if these persons were sick in their own homes he would see them only every second day. The question of mass production again comes in, so we shall credit to free medical services $2 a visit, assuming that visits are made every second day, which adds $18,600 to the $100,000 from the dispensary services.

On the surgical side of the house there were performed in the wards 1,400 minor operations at $30 and 470 major operations at $100, this charge including postoperative care. In addition those patients who were not operated upon spent 15,430 days in the surgical wards, and for these we charge $2 for a visit supposed to be made every second day. The surgical service then adds $104,430 to the total.

In the maternity department in one year 600 babies were born in the ward. We have put a flat charge of $50 per delivery on these, covering the delivery charge and after care.

These figures do not include some of the special departments, but they have already brought the total to $253,000 worth of free work given by the physicians and surgeons on our staff for the care of the ward and dispensary services in one year in a 360-bed hospital. When the time comes when these men receive even a part of the amount earned on the very low schedule of charges we have set up, then I feel sure they will be more than glad to charge their wealthy patients as little as could be desired by anyone.

Making Financial Adjustments

What is the solution of the hospitals' problems? I am not prepared to say. The private accommodations should be graded down from expensive rooms to rooms of sufficiently low prices that the people of moderate means can be cared for in a dignified and comfortable way, and the extra charges should be graded in proportion to the expense of the accommodations selected and the receipts from all private services should be only sufficient to meet the cost, no profit, or little profit being made. The physicians and surgeons on the staff should be reimbursed in some measure at least for the many hours each week they spend in the wards and dispensaries of the hospital and for their lectures to the nurses in the training school. Men who have attained the reputation and the income that would permit them, in any other walk of life, to take things a little easy, will leave their beds night after night at the call of the poor and will remain at the hospital part of the night or if necessary all night for a difficult maternity case or for an emergency operation or a medical consultation.

Ways to Get Money

These men cannot be paid in dollars for such services, but is it fair of the community to accept not only such services but daily attendance in the wards and dispensaries from both the older and the younger men in the medical profession, without remuneration? Where the money for this will come from in addition to money to cover the huge deficits incurred by the hospitals in the ward and dispensary care of the poor, I do not know. Large endowments is one answer, generous gifts each year from the public, through a community chest or otherwise is another, and taxes is a third. I was greatly interested last summer in noting that the Province of Quebec has a hospital tax imposed on meals exceeding $1 served in hotels and restaurants. I do not know how well this plan works or how much it nets.

Fortunately there are many ways in which business methods are being employed and business principles are being worked out in hospitals. A few years ago hospitals were largely managed by committees appointed by the board. One committee bought the food, another bought the medical supplies, another took care of the repairs to the buildings, another was responsible to the board for the medical services, another for the nursing services, and so on. In almost every hospital that I know of, where progress has been made and where to-day's demands are being met, there is now a modern business organization which recognizes and makes provision for the need of retaining the interest of the people of the community, through its board of trustees and its women's committees, but which will permit no undue influence in the letting of contracts, the purchasing of supplies or the admitting of patients, and which functions along the lines of the modern type of business set-up.

During the past five or six years I have seen def-

inite principles established, strengthened and finally recognized generally. Briefly these are as follows: The members of the board of trustees are responsible to the public for everything that is done in the hospital, not alone for the spending of the public's money. They employ a superintendent, administrator, director, call him what you like, who is their representative on the spot, responsible to them for everything that is done in the hospital. He occupies a position similar to that of a general manager of a company responsible to the board of directors, and he no longer is limited to the work of messenger boy, carrying out the detailed instructions (sometimes conflicting ones) of various committees. He goes to his board for definitions of policy and for instructions on major problems, and he should be so familiar with the many and varied angles of the hospital's work that he can give honest and fearless advice. He is the head of the hospital organization and all orders to the hospital personnel are given by him. The medical and surgical staffs transmit all recommendations to him, which are either acted on by him independently or are taken to the board for decision. He is the liaison officer between the board, the staff, the nursing, the social service and all other departments. The control and discipline of the interns are in his hands. They are responsible to the doctor on the case for their professional work but to the executive of the hospital for their manners, morals and contacts with the public and with other departments in the hospital.

Those who do not know what the situation in hospitals was ten or fifteen years ago will wonder why I give these facts. They will seem to be self-evident, but a few years ago the ordinary business set-up, bringing the responsibility through the various department heads to one executive who was solely responsible to his board, was almost unheard of, except in a few hospitals, and in these it had been developed largely because of the length of time in office and the personality of the executive, rather than because it was recognized as a sound policy.

Some Unfortunate Practices

I know of one leading hospital where a few years ago the social service department was administered by a separate committee and was not responsible to the executive of the hospital or to any other department. In another large hospital, the sole control of the interns still remains in the hands of a committee of the staff. Complaints of interns' manners, their contacts with the patients or their friends and of failure to be on duty naturally are made to the executive. He, however, has no control over the interns; the members of the committee invariably feel that the interns are being unjustly criticized, and we see a "house divided against itself," to the serious impairment of the hospital's good name, and with the further result that it can no longer get sufficient interns because of its unpopularity with these young men. Fortunately such cases are rare and we find a steadily increasing number of hospitals where the complete control is, under the board, in the hands of an executive who works in harmony with the public, the women's committees, his board and the medical and surgical staffs.

Coordinating Hospital Services

In the best hospital practice, the same principle of noninterference by the board in the management of the hospital is carried out in the relationships of department heads to the executive. If the executive is a doctor he knows medical matters, although he probably does not know as much about each of the specialties as do the men who are at the head of the various departments and he certainly does not know much about nursing, dietetics, social service, bookkeeping and other branches of the work. If the executive is a layman, he does not assume that he knows as much about medicine or nursing, or special therapy, or dietetics, or all the rest of the highly specialized work of his hospital, as do those in whose charge these various activities are placed.

There is always a directress of nurses who, under the administrator, is in supreme control of the nursing activities of the hospital, including the training school for nurses. She consults daily with the executive and of course if there is a difference of opinion the final decision is his, but there usually is little interference in the administration of her department. The same may be said of the chief dietitian's department and of the social service department. The departments of occupational therapy, anesthesia and physiotherapy are three other divisions whose heads are directly responsible to the executive. The x-ray department and the pathologic laboratory are always headed by physicians in the employ of the hospital, either on a salary basis or on a commission, or both.

All of the departments thus far mentioned are professional or semiprofessional. They are administered as are the various departments in a large business, except that there is I believe less interference by the executive, because of their specialized work. Other departments are those of the housekeeper, the plant engineer and the laundry.

The accounting department also has its peculiar difficulties that are not comparable to those of ordinary business, for the charges that come to it from all over the hospital originate with the pro-

fessional workers. It is difficult to persuade the operating room head nurse, who has worked perhaps for ten hours supervising from three to six operating rooms continuously in use, with more or less temperamental surgeons to be pleased, and with life and death always in the balance, of the great importance of sending the office an accurate account of the operations performed, the room or section from which the patients came and what kind of anesthetic was used, in order that the proper charges may be made at the close of the day's business. It is also difficult to make the head nurse in the accident ward see the importance of showing clearly on the charge slips sent to the office the name of the employer, in compensation accident cases, when she has had ten or a dozen patients injured in accidents to care for in an hour.

How the Hospital Keeps Its Accounts

In spite of many difficulties, great progress has been made in recent years in introducing business methods into hospital accounting. There is usually a comptroller or chief accountant who relieves the administrator of the details of this work. In several hospitals with which I am acquainted, my own included, a bookkeeping machine has been installed which classifies receipts and expenditures into as many items as may be needed and which gives the board and the administrator the detail on any special item of receipt or expenditure on short notice. Another matter that complicates hospital accounting is the number of reports it is necessary to make. In business, a report to the board of directors is all that is necessary, but if a hospital receives aid from the state or from the community chest detailed reports must be provided for both. In addition the state board of medical education and licensure, the state board of nursing education, the American College of Surgeons, the American Medical Association, the American Hospital Association and many other organizations, official and unofficial, require the filing of statistical or financial reports at regular intervals. The chief accountant takes care of most of this. Statistical records are kept in the office of the record librarian, another department head whose work is of great importance.

Last but not least is the assistant to the administrator. In almost every hospital, the assistant is the purchasing agent, and I have never seen keener buyers in any business than one will find in this group of men. The variety of supplies that the purchasing agent is called upon to purchase is remarkable, everything from an operating table to razor blades and from a case of eggs to the newest thing in maternity instruments. This gives him an intimate knowledge of his hospital which he can get in no other way, and well prepares him for the management of a hospital of his own. In addition he cares for a thousand and one things that would otherwise come to the administrator, and in his position of purchasing agent he is closer to the control of expenditures than anyone else in the organization.

Budgeting and cost accounting in hospitals have far to go before they are perfected. Except in a few hospitals, budgets are made out on a yearly basis and should of course be drawn for shorter periods and in far greater detail. In order to make the control of expenditures anywhere near perfect, supplies used in each section should be charged to that section—by this, I mean a single ward or a floor for which one person is responsible. In order to do this, adequate storeroom space must be provided so that all supplies can be issued from one storeroom under the supervision of the commissary department. In few hospitals is provision made for a central storeroom when the buildings are planned. It is to be hoped that hospital architects in the future will give more attention to the matter of a central storeroom conveniently placed and sufficiently large to take care of all the supplies required by the hospital. Such a storeroom would greatly simplify the control of supplies issued and consequently make possible a better budgetary control.

I have tried to give a composite picture of the modern hospital and of its management. The hospital business has become a large one, being, I am told, the fourth largest in the country. The Committee on the Costs of Medical Care states that "Hospitals in the United States now represent a three billion dollar investment; they expend annually about a billion dollars and employ more than half a million workers."

Difficulties That Must Be Overcome

We are doing our best to install modern business methods in this vast undertaking, and I believe we are making rapid progress, but there are certain difficulties that all the modern business methods known to man will not solve. There is the natural friction due to a number of persons from different professions working together in one workshop—medical men, nurses, dietitians, social service workers, x-ray technicians, laboratory technicians and others. Although the members of the medical and surgical staffs are the most important workers in the hospital, their services are voluntary and gratuitous. It would be difficult to imagine a manufacturing or merchandising business in which the most important workers are volunteers, over whom the administrator has no control except his hold on their loyalty. In almost all hospi-

tals, the loyalty of the staff is outstanding and truly fine, but when this loyalty is lacking and in those rare cases in which the members of the staff feel that the trustees are trying to "put something over on them" or are unwilling to give their services on the wards and in the dispensaries and to the training school, the situation is hopeless.

In addition to these peculiar difficulties, we must face the fact that our "customers" are not normal at the time they are doing business with us. When a man is ill, he is not normal, and when a person is ill enough to be in a hospital, the members of his family are not normal in their reactions to irritations and mistakes. In such circumstances delay in the nurse's response to a bell or in an intern's coming when telephoned for is magnified many times. A mistake in the hospital bill, which if made by a department store would not even be irritating, assumes tremendous importance. For these reasons and because of the constant shortage of money, I believe I am justified in stating that hospital management is in many ways different from the usual business undertaking.

What is probably most needed is a better public understanding of the hospital's peculiar problems and difficulties, so that the public may be more generous in its gifts to hospitals and patients may be more willing to pay their way.[1]

What a Properly Chosen "Greeter" Could Do for the Hospital

Why not a "greeter" for the hospital?

Hotels and even cities employ "greeters" to establish friendly, personal contacts with the public —a valuable move in building up good will.

The hospital too frequently is known as a cold, unfriendly place where the patients are cases only, where the doctors, nurses and interns are dehumanized and where "routine" is all important, according to Dr. Joseph Brennemann, chief of staff, Children's Memorial Hospital, Chicago, whose address before the Children's Hospital Association of America in Toronto, stressed the human aspect of the hospital.

"Such should not be," he said. "After all, the patient's the thing. Other activities, no matter how important, are but subsidiary outgrowths of that prime function of the hospital. And it is the reaction of the patient that is the ultimate yardstick, from our present standpoint, by which the hospital is measured. Too often there is a feeling of discontent, silent or expressed—and even of irritation, resentment and antagonism. Only too often patients hesitate, or even refuse to go to a certain hospital again because they have once been there. Why is it that an institution built on sentiment and on a spirit of service to the physically and mentally unfortunate and sick fails more often to achieve its whole purpose as compared with the hotel and the store and the movie and the gasoline station?

"The remedy may be summed up in one word—tradition. There are hospitals of which it is traditional that kindliness, attentiveness, thoughtfulness, flexibility in its conduct, and an evident spirit of cooperation and of service prevail throughout. There are others in which an obviously impersonal and inflexible chilling routine obtrudes itself. As Cushman has so well said, 'Hospitals have personalities.'

"The right man and the right woman in the high places do not set a good example—they are a good example—and they radiate a beneficent influence because they do not assume but really have a human interest in the human side of the hospital. The individual is the force that molds traditions, be he superintendent, medical chief, head of the training school, a dominant clinician, a resident, or a member of the board of trustees, or of the women's board.

"But it is not only those in the high places that radiate such influences. First impressions are strongest and most lasting and the man or woman in the 'front office' exerts an influence for weal or woe, depending on whether he is attentive or indifferent, cheerful or glum. A 'greeter,' now a part of the official welcome in some of our cities, and already installed in some hospitals, if well chosen might accomplish much. Like the poet, however, 'he must be born, not made.' "

Physician Urges Caution in the Transportation of Radium

Well lined lead boxes or containers should always be used in transporting radium from room to room, says Dr. Edwin C. Ernst, St. Louis, who read a paper on the subject of radium at the clinical congress of the American College of Surgeons in New York City.

Each hospital should have a separate room allotted for the preparation of the radium, Doctor Ernst says. This room, of course, should not be inhabited by the personnel. During the period when the radium is not in use, all of the various radium capsules, needles or radon seeds should be stored in a safe with lead protection equivalent to five centimeters of lead per 100 milligrams of radium element.

[1]Read at a meeting of the Taylor Society, New York City.

Procedures That Simplify Accounting in the Small Sanitarium

By MAURICE MELINCOFF
Public Accountant, Cleveland

THE growth of sanitariums during the past decade has been unprecedented and incredible. If Clarence Darrow is correct in asseverating that a human being is only a machine, what could be more logical than to infer that our mental equipment is being gradually shattered and sent to the human factory for repairs?

It might be that the breaking down of our mental machines is due primarily to prohibition and our fast pace of living. At any rate, mental and nervous diseases are increasing, and a book like Dr. Karl Menninger's "The Human Mind" endeavors to explain the underlying perplexing and pressing problems of our thinking deviations.

And as long as there is a struggle for the survival of the fittest in society, the nervous system and the ganglion of the weak and the unfit will be subject to everlasting tension and strain. It is this impairment of the mind and body that requires the closest scrutiny and examination on the part of the psychiatrists of the county and the state. Either the afflicted patient will be sent to the psychopathic ward operated by the city or, if funds are available, to a privately owned institution for mental care.

In this article an attempt is made to describe an accounting procedure feasible in any privately operated sanitarium or convalescent home, whose capacity might be ten or fifty beds.

Past and Present Practices

In the past institutions have found it advisable to ask a patient on entering to pay for his room and board in advance. Later a refund was made to cover any unexpired time in the event the patient was discharged or died. Today, however, a patient may hurriedly be sent to a sanitarium with one of his family or a relative and the payment in advance might not be made at the time of admission. It has become expedient, therefore, to hold the person accompanying the patient as guarantor for the bill. A special form may be used which the person guaranteeing payment may sign. If the person accompanying the patient shows reluctance to assume the guarantorship, the patient's financial rating should be thoroughly investigated before he is put to bed. A little foresight in this matter at the beginning will prevent the accumulation of numerous bad debts.

Next on a history card are recorded the patient's name, address, age, sex, date of admission, diagnosis, treatment, and other pertinent information. The history cards are kept in an index case and should be arranged in alphabetical order so that the superintendent may at any time have access to necessary information about any patient.

Preparing the Ledger Sheet

From the history card a patient's ledger sheet is prepared. On one side of the ledger sheet the charges and credits are entered as on any ordinary ledger sheet. On the other side the various charges of the patient, such as physician, medicine and laundry, are tabulated.

A chart sheet is prepared and becomes the basis for the daily extra charges and the charges for special nurses. A patient is never overcharged, because the nurse in charge always has her charts up-to-date and a daily report is written by her and sent to the office.

We shall assume that John Doe, a victim of hallucinations, is entered by his brother Ralph Doe on September 15, 1931, and that his brother signs the form guaranteeing payment of the account. John Doe's condition is such that he must have day and night nurses, and at the end of a week he becomes violent and is immediately removed to the psychopathic ward of the city hospital.

The bookkeeper will receive a report from the nurse in charge showing data on the case and will record the discharge on the history card and also on the ledger sheet. The patient's special nurse charges and extra charges will also be computed from the chart sheet or daily report sheet. When the charges are verified the total amounts are entered on the ledger under the heading, "Dates of Nursing and Charges." The totals of the different charges are next carried to the bill book.

The bill book contains four bills perforated on one sheet and it is bound in duplicate. The dupli-

cate copy is buff and the original is white. The bills are numbered consecutively, the original being given to the patient or to the person responsible for the bill, and the duplicate remaining in the book. The various charges are itemized on the bill.

When the bill is paid the receipt of a check or of cash is entered in a duplicate receipt book. This receipt can be of any size, but the book must be bound like the bill book. The receipts are also numbered consecutively, and the original is given to the payee. There may be at least eight receipts perforated on one sheet.

How Accounts Are Summarized

The patient having left the institution, the duplicates remaining in the bound bill book and receipt book are evidence of what has transpired in the way of income earned and accounts paid.

At the end of the month the income earned from the total of all the bills is summarized in the journal under the heading, "Distribution of Income Earned." Each separate bill is posted to the patient's ledger account, and the total of the accounts is debited or charged to accounts receivable in the summary entry. There is a special column headed "Patient Hours," and this total for the month provides the superintendent with the average patient day hours for the month. This figure divided by the number of days in the month gives the number of patients per day in the institution. These data are valuable for the "Ohio Uniform Annual Report for Hospital Registration."

Final Accounting Steps

It is also well to stress the point that on the chart sheets the case numbers should be consecutive and numerical, and at any time the last chart sheet should have the number for the last admittance of the current year.

The state annual report also requires information relative to the number of patients recovered, improved, unimproved and deceased. These data can be gathered from the history card or the filed chart sheets.

All the cash or checks received should be entered in the cash receipt book, and from this book the entries are made in the cash receipt journal, which has the following headings: Date; Account; Bill No.; Cash Dr.; Accounts Receivable Cr.; General Ledger. Each patient's account is posted to the credit of his account in the ledger, and at the end of the month the cash receipt journal is totaled and entered. This entry is posted to the general ledger, where the previous summary entry for the distribution of income earned was posted.

The following is a résumé of the various entries that are made at the end of the month, to show profit and loss and for balance sheet purposes.

	Debits	Credits
Accounts Receivable	√	
Income from rooms		√
Income from special nurses		√
Income from physicians		√
Income from medicine		√
Income from nurses' board		√
Miscellaneous income		√
(To record the income earned for the month.)		
Cash	√	
Accounts receivable		√
(To record the cash received for the month.)		
Accounts payable	√	
Special nursing	√	
General nursing	√	
Laundry	√	
Light and heat	√	
Dairy	√	
Groceries	√	
Meats	√	
Medicine	√	
Officers' salaries	√	
Cash		√
(To record the cash disbursed during the month.)		
Miscellaneous expenses	√	
Medicine	√	
Newspapers	√	
Office expenses	√	
Petty cash		√
(To record the petty cash disbursed during the month.)		
Laundry	√	
Heat and light	√	
Groceries	√	
Meats	√	
Dairy	√	
Telephone	√	
Accounts payable		√
(To record the expenses incurred during the month, but unpaid.)		
General nursing	√	
Special nursing	√	
Accrued pay roll		√
(To set up the pay roll unpaid at the end of the month.)		

The remaining accounting feature is the cash disbursements, whether by petty cash, check or voucher, and the accounts payable.

Petty cash vouchers should always be used when disbursing cash from the drawer, and the voucher slips should have the signature of the person receiving the cash. At the end of the month the slips are collected, and the total of the petty expenses is reimbursed by a check. When a check is drawn petty cash will be charged and cash credited, and on the vouchers paid there will appear in the journal an entry charging the expenses and crediting petty cash. The petty cash on hand and the total of the petty cash vouchers should always equal the check drawn to reimburse the fund.

Institutions whose accounts are few and whose office help is inexperienced will do well to adopt a system of paying bills by check. The voucher system is feasible in large institutions where the accounts are numerous and the bills are paid in their entirety, but for the majority of sanitariums the checking system is practical and simple. Cash disbursements are entered in the cash journal and the accounts headed are totaled at the end of the month, and the summary entry is made to the general ledger.

For bills that are unpaid at the end of the month and if the accounting is on the accrual basis, the bills are recorded in the accounts payable journal which records each bill by crediting accounts payable and charging the expense account.

What the States Accomplished in Hospital Legislation in 1931

State laws of interest to hospitals that have been passed since January 1, 1931, are reviewed in an *American Medical Association Bulletin.*

Pennsylvania passed a law to require the licensing by some state agency of all hospitals and private nursing homes of two or more beds.

Bills to give hospitals treating persons injured in accidents liens on any judgments, settlements and compromises obtained by such injured persons by reason of their injuries were enacted in Delaware, Montana and Oregon. The hospital lien law in New Jersey was amended by two enacted bills. One bill gives such liens to all hospitals, while the prior law gave it to charitable hospitals only. The other bill establishes a procedure to cancel hospital lien notices on file with county clerks, when the hospital bills have been satisfied.

A bill in North Carolina makes it a misdemeanor for a person to obtain credit fraudulently from any hospital.

A law passed in West Virginia requires all hospitals to render emergency treatment to sick or injured indigent persons and allows hospitals rendering such services to set off those charges against taxes on real or personal property.

A Missouri law authorizes the council of any municipal corporation, among other things, to levy and collect license taxes and to regulate hospitals, sanatoriums and health schools.

A New Jersey law permits any two or more associations or corporations maintaining hospitals, infirmaries, dispensaries or clinics, in the same or adjoining counties and supported in whole or in part by private charity, to merge or consolidate into a single corporation.

Under the provisions of a law in Massachusetts those licensed hospitals now designated as lying-in hospitals will be designated as maternity hospitals.

What a New York Law Provides

New York passed a law which establishes the Marcy division of the Utica State Hospital as a separate institution within the state department of mental hygiene, to be known as the Marcy State Hospital.

A North Carolina law permits any two or more counties to establish a district home for the aged and infirm, in lieu of separate county homes. A Minnesota law authorizes counties having a population of more than 50,000 and areas of more than 3,500 square miles to erect auxiliary county hospitals.

Nevada provides an additional method by which a county hospital may be established by a county or a combination of counties.

Another Nevada law provides that in all counties where a tax for the establishment of a public hospital has been authorized, the supervision, management, government and control of the county hospital, county isolation hospital, county home for indigent sick, county workhouse for indigents and county poor farm shall be exercised by the board of the county hospital.

Washington authorizes counties, or counties and cities jointly, to operate hospitals. Missouri provides state aid for counties or cities maintaining approved hospitals for the mentally ill.

An Indiana law authorizes cities of from 104,000 to 112,000 population to make appropriations to certain types of hospitals located there. Illinois passed a law to amend the law authorizing cities and villages to maintain public tuberculosis sanatoriums, by allowing any city of from 100,000 to 200,000 population maintaining such a sanatorium to increase the tax levy for its support to not exceeding one and one-half mills on the dollar of assessed valuation.

A Homelike Hospital That Serves Four New York Towns

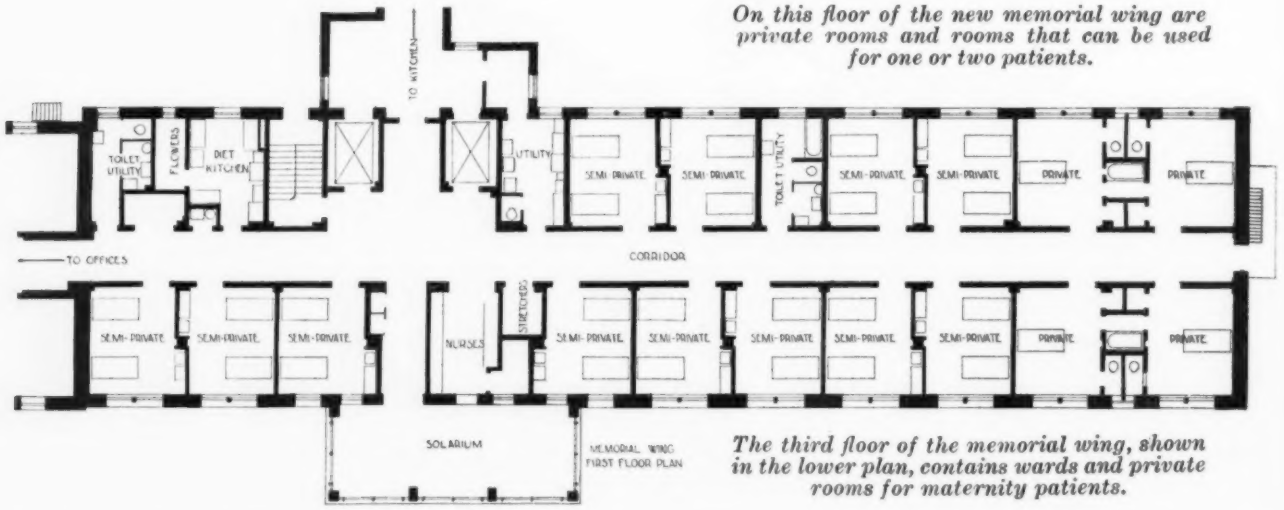
By S. J. BARNES
Superintendent, United Hospital of Port Chester, Port Chester, N. Y.
and
CHARLES F. NEERGAARD
Hospital Consultant, New York City

A MOTORIST driving between Rye and Port Chester, N. Y., on the Boston Post Road must wonder what the imposing looking brick building is that stands at the top of a hill in the midst of a beautiful grove of trees with winding driveways leading up to it from the left of the highway. He probably answers his mental question by saying, "It is a country club, a hotel or a girls' finishing school." But, if this does not satisfy his curiosity and he makes inquiries he will be told that it is the United Hospital of Port Chester.

Recognizing the aversion that most persons have towards hospitals, the officials of the United Hospital have worked to make the atmosphere of the whole place, the approach, the entrance, the entire plant so pleasing that the paramount thought of the incoming patient or visitor shall not be, "This is a hospital," but rather, "What an attractive place!" Their work has not been in vain for this is exactly the thought that flashes through the visitor's mind as he enters the hospital and—a further evidence of achievement—this impression stays with him as he is taken through the buildings.

The United Hospital ministers to the health of the citizens of Port Chester, Rye, Harrison and

Mamaroneck. The rapid growth of these communities indicated that by 1928 there would be a population of 50,000 to be served, an impossibility for a 100-bed hospital, which was the capacity of the



On this floor of the new memorial wing are private rooms and rooms that can be used for one or two patients.

The third floor of the memorial wing, shown in the lower plan, contains wards and private rooms for maternity patients.

institution at that time. To meet the growing needs of the district, in December, 1928, an intensive building fund campaign, with $1,000,000 as an objective, was launched under the able leadership of Charles D. Folsom. The financial support of the entire community was enlisted and the response was so great that the amount pledged was $1,120,000, and the expansion program was begun early in 1929.

Every Detail Shows Careful Planning

Before construction was started, however, careful consideration and study were given to all phases of the job to be undertaken, and all questions affecting the planning and equipment were discussed in conferences composed of the building committee, members from the medical staff, the architects, Raymond Hood, Godley and Fouilhoux, and the consultant.

The buildings of the hospital were in many respects like Topsy—"They just growed," without any particular plan for the future. Every addition that had been made seemed to complicate further the problem with which the architect was faced—that of doubling the capacity, adding the necessary accommodations for nurses and employees, enlarging the technical units, providing an out-patient department and in so doing reallocating the space in the old buildings to the best advantage so that the final result would be a well articulated whole with all departments properly interrelated. The problem was peculiarly acute. The old memorial wing, accommodating private patients only, had about a dozen rooms to a floor, a most uneconomical unit for nursing and other procedures. The nurses' home was so placed that it blocked what would seem to be the logical line of expansion of the hospital.

More than a dozen different schemes were worked out before the ultimate and best solution was arrived at. This consisted of an expansion of the memorial wing to the north, adding a sufficient number of beds to the existing rooms to make an economical nursing unit on each floor and providing accommodations for sixty-four private and semiprivate patients and thirty-two bassinets. There was added also a separate wing running at right angles to it, connecting by a corridor bridge

with the old hospital unit, in which was placed a rather unusual combination of services. In the basement are general supplies; on the ground floor kitchen and dishwashing; on the second floor dining rooms and a few housing units for the engineer, chef and assistant steward in the rear. On the top of all is the new operating suite, losing nothing in efficiency because of its unusual foundations, since it connects directly by corridors with both the private and ward wings.

The laundry, in a separate building, was placed at the rear of the service and operating building and connected to the hospital by a trucking passage. To meet the nursing needs of the enlarged hospital it was necessary to increase the number of nurses. As a result, a new wing, Barron Hall, was added at right angles to the old residence for nurses. Additions were made to the power house so that the heating and mechanical operations of the plant would be amply provided for, and their operation made both efficient and economical. The pathological laboratory was moved from cramped quarters on the first floor of the main building to new and enlarged quarters on the ground floor of the memorial wing. The x-ray and physical therapy departments are now housed in the main building in the space formerly occupied by the laundry and laboratory. The old operating rooms on the second floor of the main building were converted into a delivery suite, accessible to both the private and semiprivate and the ward wings.

A large proportion of beds in the old hospital were in wards, for which there was little demand. As a result, many of these beds were converted into semiprivate quarters by the installation of cubicles, and the new patient wing was planned with three full floors of private or semiprivate rooms, while the ground floor, which opens conveniently at grade, was used for a new grouping of the laboratories, with the rest given over to the care and treatment of dispensary patients. Here are to be found an adequate waiting room; examining rooms with a small entrance lobby arranged so that while one patient is being examined,

Private rooms are furnished with discriminating taste. This illustration shows the special hospital type of casement windows, hinged in the center and opening out.

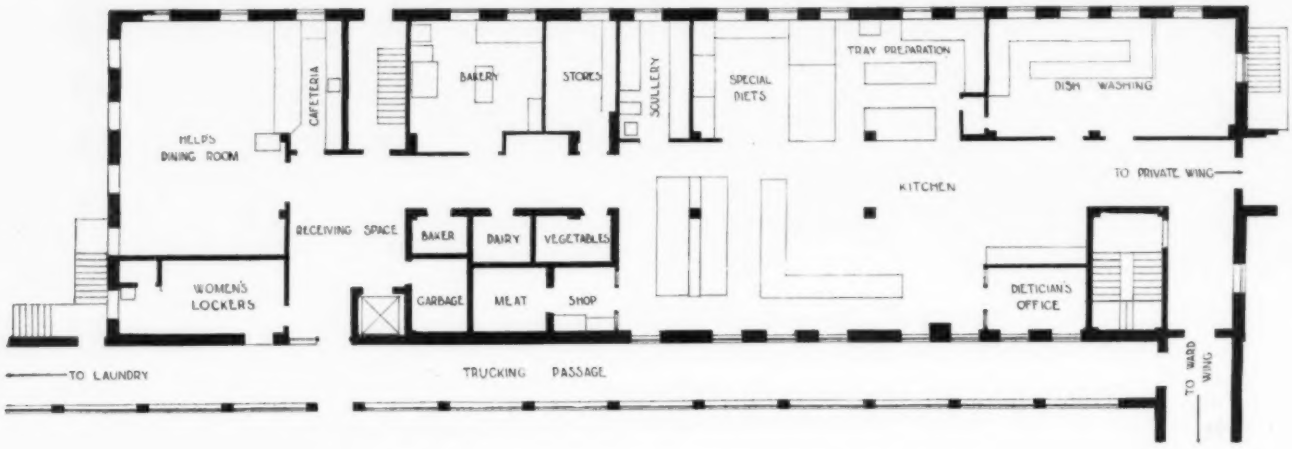
another is being prepared for examination; treatment rooms; a doctors' library; laboratories; a drug room and a board room.

The first floor is devoted to medical cases, the second to surgical, and the third to maternity. The layout of each floor is practically identical. The rooms are convertible, designed to be used as private or two-bed semiprivate rooms as may be desired. The convertible room arrangement means that the private rooms are a little larger than usual, so that when the semiprivate load is particularly heavy it is possible to put two beds into any room, all being equipped with double facilities—two built-in closets, properly arranged lighting fixtures and call systems and curtain lockers. In these are stored curtains which, when privacy is desired, can be run out at a minute's notice on an almost invisible wire, thus separating one bed completely from the other. When the curtains are not in use they are tucked away in the lockers, completely out of sight and out of mind.

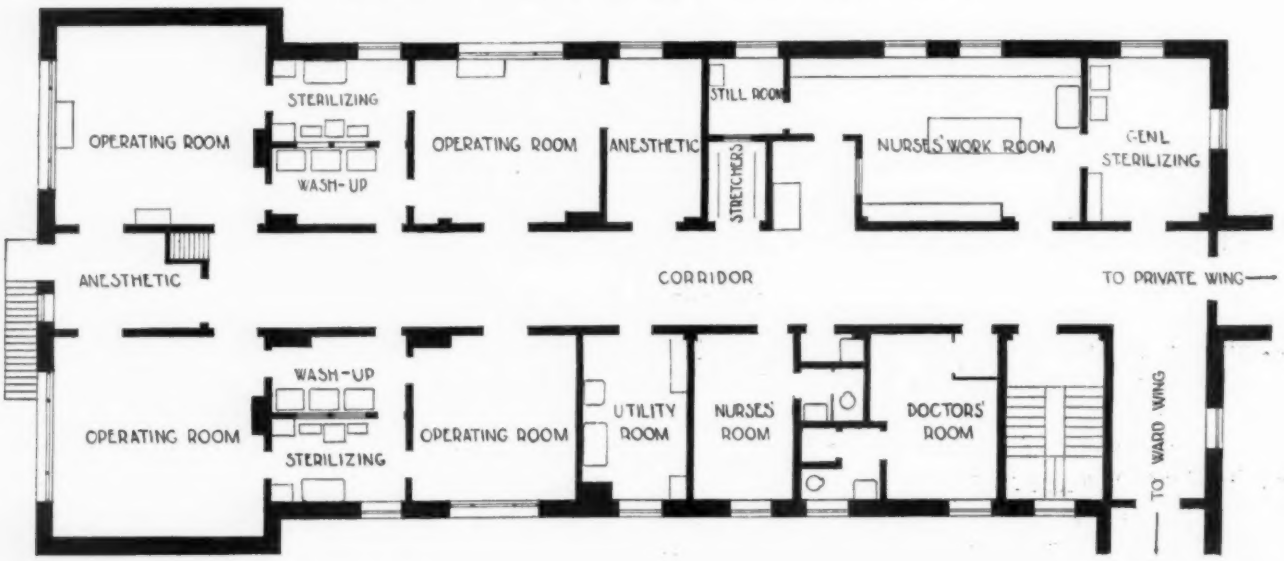
Each room is furnished with discriminating taste. On the east side of the building all the draperies are in shades of tan, and on the west side green hangings have been provided to keep out the afternoon glare. The dark red cork floors, which are easy to walk upon, and the restful cream tan of the walls give the patient as well as the visitor a pleasant impression. Several rooms have private toilets with a bathroom between two rooms. The tile in these baths and throughout the hospital is an agreeable shade of tan. Ample closet space is provided. Both built-in closets and metal cabinets have proved satisfactory.

Solariums Are Gay With Color

Special hospital type casement windows, hinged in the center and opening out, are used throughout and are a valuable asset, since they not only allow the maximum amount of sunlight and the proper amount of ventilation, but they can be opened and locked at any given point as a protection against patients falling or jumping out. They are also easily adjusted. There is an unusual amount of



These plans, of the first and third floors, respectively, show the grouping of service and operating facilities in a separate wing.



This cheerful solarium, with its unusual amount of glass area, has red and black floors and gay chintz and wicker furniture.

glass area, 28 per cent of the floor space as compared to the customary 18 per cent. These windows lend much to the cheerfulness of the solariums on each floor. The red and black floors and gay chintz and wicker furniture are also a colorful addition, making the convalescent patient eager to be rolled out to these sun rooms.

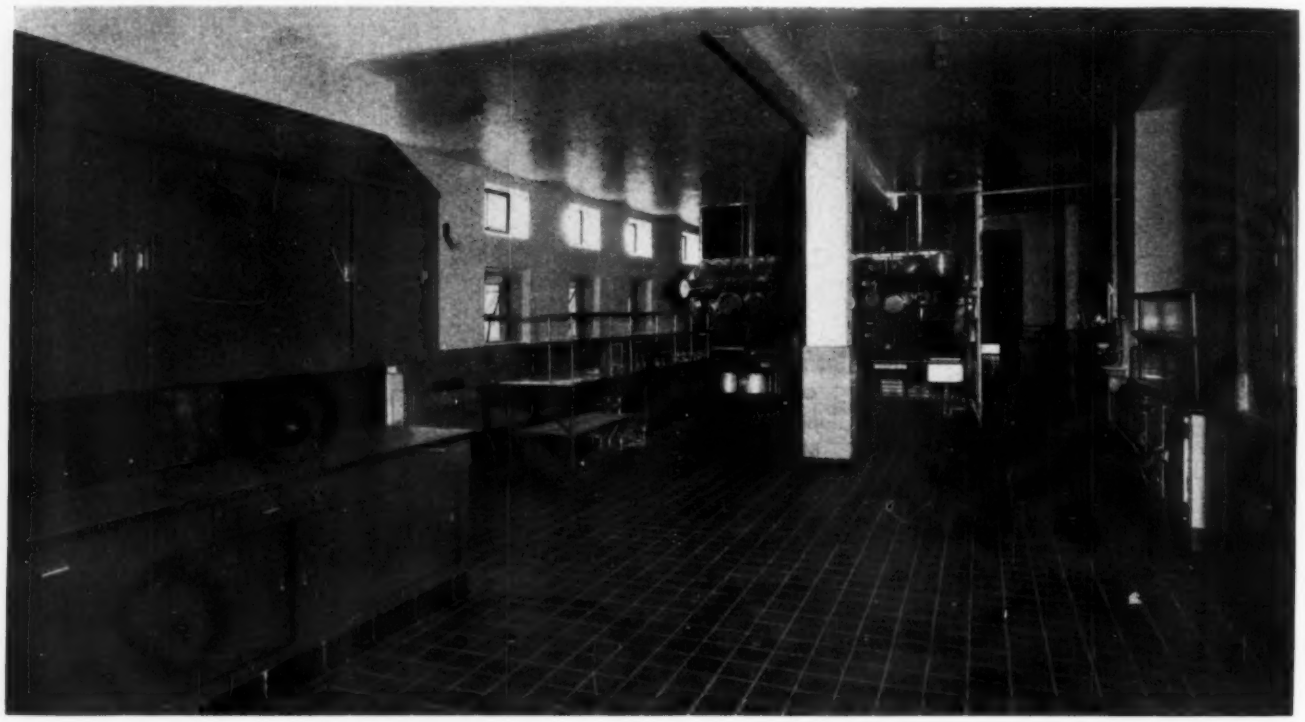
With three utility rooms on each floor so conveniently placed, the nurse finds her steps reduced to a minimum. Stretcher closets, diet kitchen, linen and housemaids' closets are also all centrally placed in an effort to make the service a more perfect one. The problem of noise control has been carefully studied. Ceilings in dining rooms, nurseries, labor and utility rooms, and in all the corridors, have been acoustically treated, with most satisfactory results. The nurseries are also enclosed with soundproof partitions. As a further protection to patients who may be bothered by the cries coming from the nursery windows, the nurseries are equipped with combined heating and ventilating units which draw in fresh air, filter it and distribute it without draft throughout the room. Thus adequate ventilation is ensured and the windows can be kept closed. Noiseless hospital hardware which prevents the doors from slamming and provides silent roller latches and rubber bumpers eliminates an old cause of disturbance.

The children's ward has been moved to the far end of the old memorial wing on the third floor and has been done over in a way that would delight any child. The roof off the second floor of this wing is arranged in resort hotel style with bright colored furniture and parasols. An hour or so of complete relaxation in this delightful place would be a panacea for many ailments.

The service and operating building, which is connected to the memorial wing by a passageway, is designed to interfere as little as possible with the light and air of all the other buildings. The kitchen, the diet kitchen, the dishwashing room, the storage room, the help's dining room, the bakery, the refrigerator rooms and the dietitian's office are on the first floor.

The kitchen represents all that is modern. Whenever practicable, up-to-date mechanical de-

vices and machine power are employed. Central tray service is being acclaimed by dietitians, employees, nurses and patients. The kitchen is so arranged that there is not a minute wasted in setting up the trays which are checked by the dietitian to be sure that each patient is getting the food prescribed for him. The trays are then sent in enclosed, unheated trucks to the floors where three minutes after they reach their destination, every tray has been delivered. This system saves time, labor and money, and eliminates the confusion usually attendant on serving patients in a hospital. At the end of the meal all trays are then returned to the central dishwashing room on the ground floor.



In the kitchen, wherever practicable, modern mechanical devices and machinery have been installed.

On the second floor are dining rooms for interns, nurses and staff. There is one serving room for all three, and it is so arranged that meals may be served cafeteria style. At dinner, when the nurses have more time, waitresses may serve them.

The careful technique and expensive equipment, which advancement in modern surgery and treatment of disease requires, are provided in the operating suite on the third floor. Here are two major operating rooms connected to two rooms for minor operations by scrub-up and sterilizing rooms; there are also anesthetizing, utility, stretcher and general sterilizing rooms. The nurses' workroom is large, well lighted and ventilated. On the other side of the hall are dressing rooms for both nurses and doctors. The tile in the operating rooms is a pleasing shade of green, and a combination heating and ventilating unit similar to that in the nurseries is employed to ensure proper air and radiation.

The new addition to the nurses' home is a four-story building which has fifty-eight single rooms and four suites with living room, bedroom and bath. The lounge, reception room and library on the first floor and the cheerful rooms throughout seem to be planned and furnished with a personal thought and an interest that create a real home. On each floor there is a small kitchenette where the nurse may prepare a cup of coffee or tea, a laundry with soft green walls and solariums where the new residence joins the old. The roof overlooks a golf course and there are deck chairs provided so that the nurses may seek relaxation in this attractive place. The two large classrooms, chemical laboratory and demonstration room are in the basement.

The laundry building like the rest of the hospital is supplied with up-to-date equipment. The washing, ironing, clean linen and sorting rooms are all on one floor. Space is provided for storing the clean laundry so that it does not have to be moved until it is called for from the hospital.

The old hospital has been altered and remodeled and connects with the new buildings to form a whole so that when the new memorial wing was ready for patients, a greater United Hospital was opened, equipped to maintain for years to come the highest standard of service.

Autopsy—The Answer to the Demand for Fewer Unfounded Diagnoses

By JOHN W. WILLIAMS, M.D.
Department of Pathology, Tulane University Medical School, New Orleans

THE ramifications of diagnostic procedure cripple the mechanism of decisions concerning the causes of death in involved cases that survive only a short time. Nevertheless, in case of death, a diagnosis is demanded and the practitioner is forced to sign a statement as to the cause even though he may have no idea of what killed the patient. It is true, too, that some cases that have been observed a considerable time, often by more than one physician, are lost after having been treated symptomatically, because the origin of the malady was never ascertained. Again, persons are found dead showing no signs of external insult but who are listed under one of the heads following the designation, "Permissible Diagnoses."

The question arises: Are the foregoing procedures conducive to the best attainments and will the physician use a reasonable amount of ability under these conditions? Most physicians will, but there are a few who are not overendowed with industriousness. For this latter class, to make a thing easy is to defeat the purpose of exactness in medicine. But what is the preventive? The only answer is, "autopsy," for, if the negligent physician fears that his diagnosis might be questioned, he will use a due amount of care, since he realizes that to a large extent his ability is his source of income.

Doing Away With Uncertainty

When the physician is not certain of his diagnosis he should say so. If authorities persist in demanding the cause of death when the physician does not know, their statistics will be of comparatively little value since it will be virtually impossible for the man who is inclined to gather statistical results to be sure of his tabulations. This uncertainty will cause a sufficient variance in the results obtained to make conclusions unreliable. This is a handicap, not only to the man who endeavors to gain knowledge by statistics but also to the man who makes the diagnosis, since it is conducive to a careless attitude. When the diagnosis is unknown, it is assumed that an effort will be made to obtain an autopsy in order to arrive at some conclusion. If the cause of death is thus substantiated it should be so recorded since it will add weight to the death certificate. For the same reason, statistics of cases in which necropsy was performed should be listed under a caption to that effect.

How Cooperating Agencies Can Help

There is no procedure more conducive to decreasing the list of unfounded diagnoses than a postmortem examination. True, autopsies may be difficult to obtain on some patients, but this difficulty can often be overcome by the correct type of approach. Some physicians are backward about asking since they feel the family is in grief and might not consider the suggestion favorably. There are few persons, however, who do not desire to know with certainty the cause of death of a loved one, and if the doctor can substantiate his clinical findings he will rise in their estimation. Some medical men feel they must supply a diagnosis to the family whether they are sure of its accuracy or not. In this case they may be unwilling to ask the family to allow the dissection lest it may reveal their lack of knowledge. It is better for the physician to be truthful with the patient's kin, to admit his uncertainty, and to feel free to ask for an autopsy and as a result to gain in knowledge and in experience.

The physician who is naturally backward frequently can enlist the aid of the undertaker in obtaining an autopsy. This may be done with finesse sufficient to indicate that it is the doctor's will and suggestion. The undertaker as a rule is a business man and will cooperate, and cooperation on the part of an ethical undertaker should do no harm. Should the physician have made considerable use of the pathologist in attempting to make a diagnosis, he may ask his aid in making clear to the family the advantage of necropsy.

There are services the pathologist may offer the physician that not only may increase his knowledge and interest in autopsy but that also stimulate him to procure additional examinations of this

type. It is suggested that hospitals and pathologists should mail to physicians upon whose cases necropsy has been performed a résumé of history, physical and postmortem findings, regardless of whether or not the physician was able to be present. This will inform the physician of errors of diagnosis and will cost the hospital clientele only a few moments of their leisure time in preparing the résumé. This record for the physician's file should prove invaluable, both from the standpoint of correlation and as a future reference.

Many will consider that since the patient is deceased there is no need of this service. This is like seeing a fire and not being interested in its cause. Natural inquisitiveness and a desire for knowledge should be sufficient in themselves to stimulate the physician to follow a case to its conclusion even though monetary compensation stopped with the death of the patient. The man of to-day should not be afraid to face the issue. He should not hesitate to admit errors in diagnosis, for he should realize that such an admission is for his own good as well as for the betterment of medicine and for the welfare of future patients.

Unfounded diagnoses are worse than deadwood. They are excess ballast, adding to the medical burden and contributing nothing to the welfare of organized society. There often is no more healthful statement than, "I don't know," for its essence opens an avenue of endeavor leading to open-minded conviction and to a feeling unhampered by the burden of uncertainty. He who does not know, should want to know and should not hide under the cloak of "Unfounded Diagnoses"; nor should he be forced to do so by authorities who demand a diagnosis in order that they may list the case under a stereotyped heading.

Conflicting Opinions on British Out-Patient Departments

Opinion of the British Medical Association on the one hand and of hospital officers on the other differs materially with regard to the treatment of out-patients, according to correspondence in the *Journal of the American Medical Association.*

The association holds that a large amount of the work undertaken for out-patients at hospitals is unnecessary; that further checks and safeguards are necessary; that the primary object of the out-patient department is for consultation; that no person, except in cases of emergency, should be accepted for treatment unless he brings a recommendation from a private practitioner, a provident or other dispensary, a public clinic or a public assistance medical officer.

The hospital officers contend that since the demand for hospital treatment comes from the patients the hospital authorities cannot keep them away; that since the patients feel that they get a more thorough examination at the hospital, any move to change this attitude rests with the profession; that since no hospital wishes to have its out-patient department overcrowded with chronic cases, every effort is made to refer patients back to their physicians.

Especially does Dr. Geoffry Evans, St. Bartholomew's Hospital, London, insist upon the patient's right. He says: "Patients must be allowed their freedom. The association's recommendation that they shall not be seen unless armed with a letter from their physician is ethically wrong. If the British Medical Association tries to tie people to their physicians and succeeds, it will collapse. It is not the first object of teaching hospitals to be consulting centers. Their first object is teaching the profession and the study of medicine."

More Isolation Hospitals Are Urged for New Jersey

More isolation hospitals are needed in New Jersey, says a recommendation made by the New Jersey White House Conference on Child Health and Protection at the central conference at the Department of the Interior.

The laws of the state permit a county board of freeholders to establish and maintain a communicable disease isolation hospital. Three counties maintain such hospitals, have a combined capacity of 785 beds, and serve a population of nearly 2,000,000. In other words, there is a ratio of one bed to each 2,400 persons. Additional facilities, however, are in prospect when the Jersey City Isolation Hospital begins operation.

Eight municipal isolation hospitals are also maintained in the state with a total capacity of 500 beds.

More than 5,300 patients were treated in these twelve isolation hospitals last year. Looking at the state as a whole, of the twenty-one counties, communicable disease hospitals to some extent at least are available in each of ten counties.

It is recommended that isolation hospital facilities be increased to meet local needs. Counties are specifically designated where this need is apparent.

The conference further recommends the grouping of small townships and municipalities into districts sufficiently large to make practical the maintenance of a health department with full-time, qualified employees.

How Hospital and Public Health Work May Supplement Each Other

By H. J. SOUTHMAYD
Director, Division of Rural Hospitals, Commonwealth Fund, New York City

THE most casual observation will reveal some evidence of hospital and public health relationship. There are, for example, the administration of communicable disease hospitals by the health department and the supervision of maternity hospitals or the varying degrees of responsibility for hospitals generally given to health authorities by certain cities and states. Such examples, however, are only in the nature of straws pointing to some vague and distant relationship. They are regarded rather as exceptions to the rule. They are not typical of either field. They do not proclaim a broad, generally recognized and active relationship.

In approaching a discussion of the subject of the relationship of hospital and public health work, I should like first to establish on purely rational grounds the fact that every important phase and aspect of hospital and public health functions point to the opportunity for and the desirability of establishing between these two an intimate and profitable working relationship of fundamental and vital consequence to humankind. Then I should like to show that there is a growing recognition of the practicability of this idea and follow with suggestions of how and why hospital leaders may and should participate in this movement.

An Identical Objective

In first year "high," I had a mathematics teacher whose favorite axiom recurs to me as I think of the relationship between public health and hospitals. Day after day I heard that "things equal to the same thing are equal to each other." To me the hospital-public health relationship almost adapts itself to this axiom, but I should like to paraphrase a bit and say that "human institutions having an identical objective must bear a close relationship to each other." This fits the hospital and public health fields, because undeniably the sum of all the efforts of both institutions has the identical objective of conserving human life and health.

No claim is made that these institutions themselves are identical, but it is more than conceivable that some day they will be more clearly recognized as parts of a whole. For the present, however, there are differences in tradition, form, method and support, all of which serve to explain but not to justify the attitude of distant relationship that the hospital and public health movements tend to preserve toward each other. The essential difference is in the method of approach to the common goal. In the hospital, emphasis is placed on rehabilitation and the individual; in public health the key word is prevention, with emphasis placed on the health of the community at large. Likewise, there are similarities. Both institutions are the result of group effort; they are publicly supported, notwithstanding the fact that public health is tax supported while hospitals depend upon philanthropy. The same arts and basic sciences underlie their essential functions, the same professional personnel are engaged in their characteristic work.

Signs of the Times

So we have these two institutions with the common objective, both publicly supported, both drawing upon the same store of special knowledge and staffed by the same professional personnel, each growing practically independently in something of an atmosphere of self-sufficiency as far as the other is concerned. Such a situation might be justified if the differences were vital. The fact that one deals principally in preventive measures for the group and the other in curative measures for the individual should constitute no serious obstacle to a concerted effort. After all, these differences are rather of the complementary kind in view of the main question of preserving life and health. The public health in the end is the sum of individual health and it is of little significance in broad perspective whether health and life are conserved through prevention or rehabilitation, or whether the problem is attacked from the individual or the community standpoint.

Are there any signs that this apparently rational relationship is being recognized? Happily

there are a great many, particularly in the more recent years. About five years ago the American Public Health Association, representing national thought in the public health field, appointed a special committee to inquire actively into this relationship. The American Hospital Association cooperated in this study through its established committee on public health relations, which offers another sign of the times. The American Hospital Association has also adopted resolutions favoring the hospitalization of acute communicable disease and tuberculosis in general hospitals. It is well known that acute communicable disease and tuberculosis are of primary interest to the public health agencies. Hospital periodicals have interested themselves in this subject. The best evidence, however, of the recognition of opportunities for establishing a working relationship between the hospital and public health is the fact that both institutions are engaging in activities which as recently as ten years ago were regarded as belonging in the field of the other.

For a generation at least it has been increasingly clear that in their natural growth the boundaries of the fields of hospital and public health have tended to approach each other. Now the hospital is no longer exclusively concerned with the individual as is shown by the rapid growth of the out-patient department, which distinctly implies an interest in the community or the public health. The extension of the out-patient activity is not only one of degree but also of scope and of character, added clinics frequently being preventive in nature. Neither does the hospital proper now limit its interest to remedial measures. How about many of the surgical operations on tonsils, gall bladders and appendixes? Are not many of them in the preventive field and do they not constitute a considerable part of hospital activity?

Public Health Today

On the other hand, public health is emerging or has emerged, depending upon the community, from a stage of exclusive concern with sanitation and communicable disease, and in this transition it is finding it necessary to view the public health from the standpoint of the individual in order to give protection to the community in the light of present day knowledge and social organization. The tendency of these fields to merge has now progressed to the point where the picture is one actually of overlapping in their functions, hospitals and public health departments often carrying on essentially the same activities, sometimes, regrettably, in a spirit of rivalry and competition.

Even in the form of public support, the respective fields of these institutions are drawing more closely together. Typically, the general hospital in this country derives its support from private philanthropy, but each year shows an actual and relative increase in the number of tax supported beds in general hospitals. The typical public health activity is a governmental agency, but more and more is it being assisted by nonofficial public health organizations supported by private funds. In a word, these institutions themselves by their acts give the best evidence of their intimate relationship.

A Game That Two Should Play

The picture thus far is one of encouragement because of its natural development. We should be lacking in ordinary good sense and judgment, however, if we did not recognize the dangers of duplication and waste and at the same time the opportunities for increasing the usefulness of both institutions in their progressive intermingling of function.

Before passing on to a discussion of definite points of contact around which an orderly plan of cooperation may be developed, I should like to mention the work of the committee of the American Public Health Association which has taken the initiative in this matter. One result of this committee's work was the compilation of twenty-five hospital questions, the answers to which the committee believes should be known to the public health officials in any community. In effect, the answers to these questions constitute a thorough survey of the hospitals of the community, their scope, capacity, method of support, volume, cost and standards of service. In a word, public health authorities believe local health officials should know about all there is to know about the hospitals in their community. It seems to me that this is a game that two should play. I believe the hospitals should return the compliment and inform themselves on the status of the public health administration of the community as a preliminary step toward better cooperation.

In studying the reports of this committee, to which I am indebted for ideas as well as for facts, I was struck by the significance of one of the several statistical tables which revealed the relative return of replies to the committee's questionnaire from health officers and hospitals. The proportion of returns from hospitals was only about one-half of that from health officers. Making due allowance for the fact that the health officer was answering a questionnaire sent by his national organization, I was disappointed in the hospital return which was appreciably less than one in three. It seems to indicate that public health has a greater interest in hospitals than hospitals have

in public health. This interest, I maintain, should be equal.

With regard to opportunities for establishing working relationships between hospitals and public health organizations, there are at least five points of common interest, which may be defined by the terms, communicable disease, clinics, laboratory, field nursing and vital statistics. Both hospitals and public health organizations may have definite responsibilities in connection with any of these activities or may voluntarily engage in them.

The question of hospitalizing communicable disease in a general hospital probably is the one that meets with the greatest opposition by the public and by hospital authorities. This opposition is based on the outworn theory that it is dangerous to hospitalize communicable diseases within city or town limits, to say nothing of the caring for such cases on the same lot or in the same building with general hospital cases. It is being done and has been done for some time, both here and abroad, and the national hospital organization has approved of the practice. It is folly to set up a separate expensive hospital plant and administration for the special care of communicable disease in a community of less than 100,000, according to the American Public Health Association. The alternative, therefore, is either general hospitalization or no hospitalization of communicable disease. It does not seem that the choice should be difficult to make.

Many of the same arguments hold for clinic and laboratory facilities. There are countless instances in small communities to prove that the services of the single laboratory in either the hospital or the health department are adequate for both. In most of these cases, however, one or the other is getting along without the advantages of laboratory service. It is a matter of regret to hospital planners that clinic space must remain idle many hours each day, especially when the health department owns or rents duplicate facilities that are likewise idle much of the time.

What Is Field Nursing?

By field nursing is meant a nursing service that is given to patients or families in the home, at present typified by the staffs of nurses working for the health department or for a nonofficial public health agency. This service, which is generally known as public health nursing, now is primarily educational but in some places the actual care of the sick is undertaken on an hourly or visit basis. At the same time hospitals are beginning to send nurses and other personnel into the field to follow up cases discharged from the hospital in order to make the most of expensive hospital care, a procedure which, by the way, permits an earlier discharge from the hospital with a consequent saving in a great many cases. Logically, one field nursing service in a community should be sufficient to render services for both the hospital and public health agencies.

On the question of vital statistics, I believe that a satisfactory relationship is making progress. If a hospital does not have strict regulations and has not set up a procedure whereby the health department is promptly notified of the presence of communicable diseases in the institution or does not make it easy for the staff members to report births and deaths, by all means this should be a first step toward establishing a cordial relationship with the local health officials.

If these suggestions appear to be visionary and if there is any question in the minds of hospital administrators as to the practicability of setting up relationships with the health department along these lines, it might be well to consult the reports of the American Public Health Association which cite numerous instances where such relationships are in effect. These reports are available at the office of the association. If these relationships are desirable and are found workable, as they have been here and there over this country and to a greater degree in other countries, I can see no good reason why they should not be generally adopted elsewhere.

Combining Forces in Health Activities

As to the initial approach to the subject locally, I can think of no better plan than setting up a joint committee consisting of representatives of the governing groups and executives and perhaps the most interested department heads of these institutions in the community. Such a committee, of course, would be informal and unofficial. In larger communities where the hospitals themselves already have organized a council or comparable organization, such a committee already may be found. In smaller communities that have only a few hospitals, some difficulty may be experienced in getting joint action by the hospitals themselves. In such a community the initiative might be taken by the health department, stimulated by one or more of the hospitals. In a community that has only one hospital the task should be simple since generally those who are interested in the hospital are also those who are the most interested in public health developments, or at least they are the ones who can be interested. If the public health administration is weak and not inclined to cooperate, the hospital may work through its supporting organizations, by no means forgetting

the women's auxiliary, in an effort to strengthen the health administration.

Specifically, this joint committee should discuss and agree upon combining forces in the activities suggested: the common use of clinic and laboratory facilities; uniform report and record procedures of mutual interest; a community program for the general hospitalization of communicable diseases, and the utilization of public health field nursing services for the reference of cases to hospitals and clinics as well as for needed follow-up of cases that have been discharged from the hospital.

How Both Will Benefit

Finally, why should such an effort be made? Has the hospital anything to gain? We believe that it has. Hospitals, more than most other institutions, business or social, for gain or for charity, are dependent upon public good will. The knowledge that the hospital has adopted a forward looking program of wider and deeper significance, looking at the same time toward public economy, cannot fail to attract favorable public notice followed by increased public support. Surely no harm can result to the training school, for instance, if it is known that the hospital provides a communicable disease service. How could the public reaction be other than favorable if it is known that the hospital's clinic space is working six hours a day instead of three or that the laboratory has greatly increased its output by doing public health work, particularly if these arrangements are accompanied by financial terms favorable to the hospital, as should be the case, or if the laboratory service has been added by making the health department laboratory available at a nominal cost?

This development should have the hearty support of both hospitals and public health because, first, under a common program each institution will do a better job. Doing a better job in the hospital and public health fields means the most that any human effort can mean—saving human life and health. Second, a good job will be done at less cost. The practical significance of these two arguments is that more and better work may be done at the same cost.

Those responsible for hospital and public health activities are engaged in a public trust. They cannot fail to take advantage of every opportunity to effect economies and raise the standard of their services and at the same time to claim a faithful discharge of their trust. Such an opportunity, I am convinced, exists in the idea that public health and hospital relationships may be greatly extended far beyond their present status.

How a Nurse Is Trained at a Famous Old French Hospital

"It is the right of the sick to be exacting, and the duty of the nurse to be patient."

This is the axiom on which the nurse's training is based at the Hotel-Dieu, Beaune, France.

The various steps in the nurse's training at this famous old hospital are outlined in the *Irish Nursing and Hospital World* as follows:

"Having decided to take her training as a nurse, the young student has her first experience with a patient the day after her arrival. This first period is brief and superficial, but it is sufficient to show the spirit of the hospital. She begins by attending to convalescents. While learning the routine duties she endeavors to develop in herself the qualities of gentleness and alertness. A thousand little services are required of her which try and temper her patience until she is convinced of the axiom that must be hers through life: It is the right of the sick to be exacting, and the duty of the nurse to be patient.

"The student then enters a medical ward. There she learns to watch and observe; she tries to distinguish among the countless incidents in a fever patient's day which deserve the attention of the doctor. She also begins to acquire nursing technique—injections, cupping, bandaging, and so on. She becomes skillful in minute motherly and soothing attentions—small details of toilet, settling of pillows, changes of position, all of which so greatly relieve the patient.

"She is then transferred to the surgical service. In a men's ward she has to dress the wounds of operated cases, and often those of victims of accidents. From day to day she becomes familiar with wounds of all kinds, from erosions to traumatisms. In a women's ward she will study operative cases, and learn the many kinds of treatment they need.

"After this, her training becomes more thorough and more time is devoted to it. She works for a certain time in the operating theater. She spends some time in the dispensary becoming acquainted with the elements of materia medica. She also spends a few weeks in the manager's office to gain some idea of hospital administration, and a few months in the kitchen where she learns to realize the importance of dietetics by drawing up special diet cards and preparing savory dishes.

"Theoretical instruction in anatomy, physiology, treatment and care of the patient, and ethics of nursing is given weekly during training.

"Little by little, step by step, without hurry or pressure, application and forgetfulness of self imbue the student with that spirit of charity which will henceforward be her joy and her purpose in life."

The Small Hospital Executive as a Publicity Agent

By FRANK W. HOOVER
Superintendent, Elyria Memorial Hospital, Elyria, Ohio

THE most urgent need of many of our hospitals in towns of less than 50,000 population is a proper understanding by the public of the work of the hospital. To the average layman, the hospital is the place where members of his own family are taken only once or twice in a lifetime and, except at the time of community chest or other hospital fund drives, he gives it little thought.

The Menace of Gossip Mongers

One of the great dangers that confront the small hospital is the fact that the superintendent is unaware of the unfavorable gossip that is constantly in circulation about his institution. It starts something like this. Mrs. Jones meets Mrs. Brown and in breathless eagerness asks, "Did you hear the latest about the hospital? I have felt for a long time that things were not just exactly right up there. One of the doctors does not park his machine in front of the hospital but drives into the alley at the side. In a little while one of the nurses comes out and sits in the machine. Presently he comes out, gets in and they do not drive away. Something ought to be done about such goings-on. We can at least air our opinions at the next meeting of the Ladies' Missionary Society."

Another typical story, usually with less foundation or none, is that some member of the police department is spending too much time at the hospital. Of course, most persons should know that some member of the police force is assigned to make an immediate check-up on all automobile accidents after they occur. If anyone has been seriously hurt, the victim and the witnesses are usually congregated at the hospital and, as is often the case in a small town, the same man makes all the investigations in the daytime and another investigates all accidents that occur at night. Naturally, the police department and the nursing staff become acquainted and there is some friendly banter between the police and the nursing staff during these investigations. It takes only a few idle tongues, however, to start a scandal about the member of the police department which perhaps ruins the reputation of the best man on the force and besmirches the good name of the hospital.

These are typical examples of unfavorable publicity that the superintendent never hears. Other examples of unfavorable publicity he sometimes knows about are the stories of neglect to patients. If there is one rule that every hospital superintendent should follow in a small town, it is to make up his mind that he will never allow to go unchallenged a statement that there has been neglect of patients in his hospital. He should ask his trustees to get the names and dates on any story that they hear. He must not overlook the most casual remark. It is his obligation to trace it back to its source and get the complete story. If it is untrue, the person who started it should be branded as a prevaricator. If it is true, then the superintendent must let the public know that a thorough investigation will be made and the offender properly punished. These examples of a type of unfavorable publicity have been given to impress upon the administrator's mind the need of every hospital for favorable publicity.

Offsetting Unfavorable Publicity

A discussion of unfavorable forms of publicity should also mention the fact that almost every small town paper, in writing its death notices is very specific as to the place of death, and although the superintendent may not realize it, the only thing that some persons in the community know about the hospital is that John W. Smith died there last week and that Henry Jones was taken there from an automobile accident the week before and died soon after.

At this point, many superintendents will ask: "What is favorable publicity and how may I obtain it?"

It is eminently worth the while of any superintendent to take the trouble to tell the local newspaper each morning that Mr. and Mrs. William Brown of Park Avenue are the proud parents of a daughter born at the hospital. He may offset the chill of the death notices and silence the comment that is frequently made that "Nobody ever leaves that hospital except feet first," by giving a list of

the patients that have been discharged to their homes. If any of the patients discharged are prominent socially or if they are persons who have figured in accidents, this is important news in a small town.

Several times during the year the superintendent will have important announcements to make about the work of the hospital. When this time comes, he should have his story typewritten and take it to the city editor or the editor of the local newspaper. The time of the day that the story is carried to the newspaper must be considered. If it is taken in between 2:30 and 3 o'clock in the afternoon, when the big presses have started to work, the editor will be relaxed and ready to look over the story. If he is approached between the hours of 12 and 2 o'clock when every employee of the office is under a terrific nervous strain, he will of course have little time to talk with the superintendent and the article may receive little consideration. Another common mistake for the superintendent is to take in a story the forenoon of the day he wants it published. If it is a story that has to be published that day to be effective, it may land on the sport page or among the "For Rent" ads. If it is taken to the newspaper office the day before, the editor has a chance to plan the make-up of his paper so as to give the story a favorable location.

Making Friends With the Editor

It is important for the superintendent to establish friendly relations with the editor or the city editor, because the reporter who is assigned to cover hospital news does not have the authority to give any story a favorable location in the paper. The superintendent may discover that the editor is interested in some particular phase of hospital work. He may be interested in the x-ray department, the laboratory, the nursery, or he may have a secret desire to see a surgical operation performed. It is to the superintendent's advantage to grant any reasonable request he may make. He may, also, be prejudiced against the hospital, because of a lack of courtesy on the part of hospital employees in giving out information on accident cases. Should this be the case, he should be made to understand that, in the case of a factory or a railway accident, the company paying for the hospital services usually wishes publicity kept to a minimum and that frequently there are cases where some sick member of the family would be seriously affected by a full story of the injuries received by an accident victim.

Of course, the best publicity that any firm receives is the word-of-mouth advertising by satisfied customers. In the same way, no amount of newspaper publicity can ever take the place of the publicity received from grateful patients whose health has been improved, whose lives have been saved and who have received courteous, friendly treatment from all members of the hospital organization.

With the purpose in mind of improving the service of his hospital, the superintendent will receive many helpful suggestions from his patients, as well as many expressions of appreciation of good service, if he will send each patient a card soon after he has left the hospital, inquiring as to the improvement in his health and asking for suggestions.

Good hospital service, like good hotel service, consists of many thoughtful little courtesies, which are not absolutely essential to the patient's physical well-being, but which help tremendously his mental state and nurture a feeling of friendliness for the hospital. This type of service is a result of constant supervision and continual suggestion by department heads and members of the supervising staff.

Probably the most potent publicity of all is the good word spoken by the members of the medical staff to the prospective patient. The view of the hospital that the prospective patient gets from his family doctor is naturally colored by the doctor's opinion of the hospital. It behooves every superintendent then to keep in close touch with the medical staff, to listen carefully to every complaint of poor service and then convince the complaining physician that action has been taken on his report and that every effort is being made to carry out his orders and to satisfy the patient.

Any hospital organization must of necessity be a complex one, and unless there is a diplomatic effort to maintain harmony, as well as strict discipline, there cannot be that cooperation which is necessary if the hospital is to maintain its good name in the community.

Grasslands Hospital's Program of Adult Education

Grasslands Hospital, Valhalla, N. Y., is conducting its second class in adult education and many patients are taking advantage of the courses offered. A class of ten tuberculous patients was graduated recently and given certificates "for satisfactory work in an introductory course in secondary English, including letter writing, spelling and the use of reference books." With the second class, these subjects are being continued. So far the courses have been successful in contenting the patients and imparting useful information.

Where Diets Are Made Both a Science and an Art

By RHODA A. TYLER, B.S.
Dietitian, and
C. W. MUNGER, M.D.
Director, Grasslands Hospital, Valhalla, N. Y.

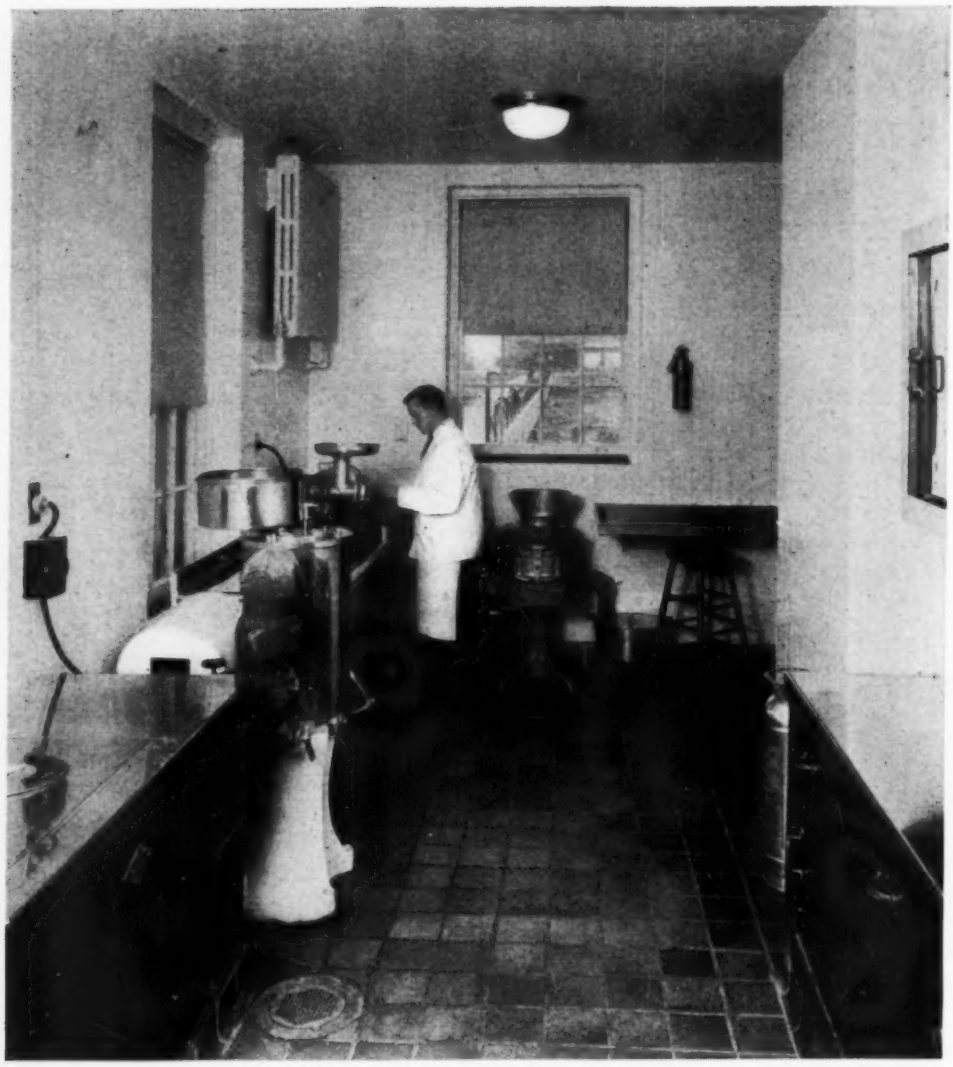
THE aim of a hospital dietitian and her staff should be to prepare and serve all meals attractively, palatably and economically. At the same time, they should keep pace with the modern scientific advances in the field of nutrition and dietetics.

The dietitian must keep the patient content with his diet by individual contacts with him and she must instruct him concerning food elements and combinations of foods so that he may continue his diet when he leaves the hospital. If in addition the dietitian realizes and utilizes the educational possibilities of her routine work, she can make a substantial contribution to the public health and welfare. The work described here represents one hospital's attempt to accomplish this ideal.

Grasslands is the 860-bed county hospital of Westchester County, New York. At present there are four buildings for patients, all connected by enclosed passageways. The main building, in itself a general hospital, accommodates 500 patients in twenty wards including medical, surgical, obstetrical, pediatric, orthopedic, chronic and communicable and venereal disease. The psychiatric institute has a capacity of eighty beds. Here mental cases are observed and diagnosed and hopeful cases are treated. The preventorium, known as Sunshine Cottage, cares for ninety undernourished and tuberculosis contact children. A tuberculosis building for adult cases accommodates 190 patients.

The general diets are served from the large kitchen in the main building for all departments except Sunshine Cottage. The food is sent to the wards in the main building in insulated food trucks and the patients are served from the truck as it passes through the ward. The charge nurse directs the serving. This method brings hotter food to the patient and, since he has an opportunity to express his likes and dislikes, there is less waste. Small dining alcoves are arranged near each ward pantry, where ambulatory patients are served at tables.

Food is sent through the passage to the psychiatric institute, a separate building, in a large electrically heated truck. The nursing units in this building are from eight to eighteen beds' capacity, to assure a proper classification of cases. A separate truck for



This well equipped food preparation pantry facilitates the serving of meals that are prepared in the main kitchen and sent to the wards.

each unit is out of the question, but each unit has a bain-marie in which food is kept hot after delivery.

Special medical diets and children's diets for the main building are served from the main diet kitchen.

The medical diets, which average from sixty to eighty daily, regularly include diabetic, nephritic, anemia, gastric ulcer, cardiac, low protein, typhoid, low caloric for obesity and high caloric for underweight. Central service by heated and unheated tray carts is used.

The diet for older children consists of cereals, dry toast, puréed vegetables and fruits, scraped beef balls, soft cooked eggs, minced liver and chicken and occasionally bacon.

A general menu is prepared for all patients. The special diets are arranged from this menu by additions or eliminations.

Special diets are important in the modern treatment of tuberculosis. For that reason the new building has a fully equipped special diets' kitchen, designed to operate on a central tray service plan, for the medical diets for tuberculous patients and for patients in the adjacent psychiatric institute. Numerous low residue diets are required for patients with intestinal complication of pulmonary tuberculosis.

The dietitians or student nurses from the diet kitchen visit the patients to discover their likes and dislikes and their attitude toward the diet, to give instruction as to the purposes of the diets and to strive to encourage each patient to continue his diet in accordance with the physician's orders.

The food for nephritic and cardiac diets is prepared without salt. Salt is not served on the trays. Vegetable or cream soups are used. One egg is served each day, fish on Friday, chicken on Sunday. Vegetable and plain salads are included in both the noon and night meals. Desserts are prepared without salt. Fruits or fruit flavors are added to increase the palatability of the food.

The food served to the diabetic patients is calculated as to the amount of protein, fat and carbohydrate and as to the calories. These figures are entered upon the medical record so as to be avail-

Toast and soup, piping hot, and crisp salads are served from this serving pantry, which also contains equipment for washing dishes.

able to the physicians. All the food is weighed under supervision by student nurses or student dietitians.

The ultimate benefit which the patient derives from the dietetic phase of his hospital treatment depends largely upon his mental attitude toward the diet, as well as upon the extent to which he is made to understand its purpose and importance. The nurses and dietitians can give some of this instruction in their daily contacts with the patient.

Before the patient who has been on a diet for gastric ulcer, diabetes or nephritis is discharged, the social worker refers him to the dietitian for a sample diet with perhaps some simple recipes to assist him in carrying on, in his own home, the diet he has been following successfully in the hospital.

Frequently the patient is given an appointment for an interview with the dietitian at the time of his follow-up visit to the out-patient department. If the dietitian finds that for one reason or another the diet is not being adequately carried out, she in turn calls in the social worker to straighten out the difficulty, be it economic, educational, environmental or emotional. This cooperation with the social service department permits a study of results over a longer period of time than is possible during the patient's hospital stay.

The hospital's postgraduate course in dietetics is approved by the American Dietetic Association. The dietary department cooperates with the school of nursing and with the intern instruction of the medical department. These and other departments reciprocate by holding lectures, consultations and conferences for the benefit of student dietitians. Besides the instruction in special diets, the student dietitian gains experience in large quantity cookery in the main kitchen and bakery. It is during these periods that she computes the caloric value of desserts and meals and also the separate per capita costs for the general hospital, the tuberculosis, the psychiatry and the staff dining rooms. The average cost of raw food for patients in 1931 was forty-seven cents per capita per diem.

During the student's two weeks in the infant feeding laboratory she prepares from fifteen to

Good kitchen equipment improves any dietetic service, and that at Grasslands Hospital is surely above the average. These two views of the main kitchen show part of the up-to-date tools that aid the personnel in their work. Tile has been employed for the floors and walls and noncorrosive metal for the sinks and table tops.

twenty formulas a day and carries on a case study of one infant. She also figures the caloric value of all formulas for the content of protein, fat and carbohydrate, and the caloric value per pound of body weight.

The instruction of the student is not confined entirely to the dietary department. In the housekeeping department she makes rounds with the housekeeper and observes the methods of cleaning in the wards, in the nurses' residence and in the employees' building.

She also is instructed in the system of requisitioning and ordering of all hospital supplies and observes the methods used in obtaining bids and the general procedure of receiving and distributing. She assists in the hospital receiving room when requisitions are distributed to departments.

The student has an opportunity to observe the methods of a large, well organized purchasing department. All the purchasing for the hospital is done by the steward of the public welfare department of which the hospital is one division. Each division sends requisitions in advance to the steward, who then submits specifications for each article on the list to three or more firms, with requests to bid. As bids are received, the orders are relisted and the order for each item placed with the lowest bidder. As goods are received they are checked as to compliance with specifications and are distributed to respective departments.

Sunshine Cottage, the children's preventorium, as a separate unit has its own complete kitchen and dining room, permitting careful individual attention to the dietary problems of these children, as well as special dietary studies with problem children.

The children's dining room has a southern exposure which affords plenty of sunshine. The floor covering is rubber tile with interesting animal inserts. The small tables have brightly colored linoleum tops and are of heights adapted to the various age groups.

The kitchen is equipped with modern electrical machinery, such as an ice cream freezer, a mixing machine, a food chopper and a potato peeler. The tables, cabinets and refrigerators are of noncorrosive metal. The serving table is equipped with an automatic egg boiler and toaster. Precautions against infection were considered in the installation of a dishwasher with a sterilizing attachment.

Here dietitians personally supervise the feeding of undernourished children.

Feeding Undernourished Children

The aim of Sunshine Cottage is to build up the physical health and the resistance of children who are undernourished or who have had contact with tuberculosis, thus alleviating danger of illness later in life.

Diet is naturally an important part of the treatment for each child in Sunshine Cottage. The dietition works closely with the physicians in charge of

the children. A school is maintained and the dietitian of the cottage assists the school teachers in dietary instruction and demonstrations. In the cookery classes children are instructed in menu making and in preparing a whole meal. The teacher cooperates with the dietitian in teaching table etiquette and correcting food habits.

In a recent analysis of the diet, the calcium, phosphorus and iron contents were found to be more than adequate, as were also basic food elements and total calories. A research study in cooperation with the department of laboratories is in progress, in an attempt to determine the effect that adding certain vitamins to the diet will have upon nutrition. Since the average child stays several months, there is excellent opportunity to observe results. Under the regular diet, the children's gains in general health, in hemoglobin content of blood and in weight are gratifying.

The work described in this article requires the services of one chief dietitian, one first assistant dietitian, three divisional assistants and one relief dietitian, plus the help of student dietitians and nurses under instruction. The opportunity to instruct patients, the social service follow-up, the unusual variety of medical problems encountered, the activity of the special medical diet work, the planning of the transportation and serving of food for both bed and ambulatory patients in four different buildings all combine to hold the interest of the dietary staff and to give unusually complete experience to students.

How One Australian Hospital Welcomes Its Patients

When patients are received at the Langton Clinic, Sydney, New South Wales, they are welcomed as guests rather than as customers and are assured the hospitality of the hospital by means of the following memorandum which is handed to them immediately upon their arrival at the clinic:

"Guests arriving at your home are not subject to rules and regulations. Their kindly consideration for the convenience of their host makes them eager to fit in with every arrangement you have made for their comfort.

"It is the same in this clinic. The rules and regulations are few and simple, and your cooperation is sought in the healing hospitality which is here extended to you.

"The board of management of this hospital desires that you should consider yourself as a paying guest entitled to all the privileges extended to all members of this household.

"The united effort of all the hospital helpers is to make you well as quickly as possible.

"On the first floor the telephone is available in each room and you are entitled to make any local, interstate or overseas calls that you wish. These will be charged to your account when leaving.

"The signaling system will be explained to you in detail by the nurse on duty.

"The matron will see you each day and the superintendent every other day. You are invited to give either your views regarding anything at all which would make you more comfortable or happy during your stay.

"Daily papers can be ordered morning and afternoon and will be brought to your bedside.

"A typist is available, if you desire to dictate letters, the cost of each letter including stamp, stationery and service being only sixpence.

"The library can be brought to your bedside each day. If you want any particular book that is not available, ask the matron for it.

"Fresh oysters can be delivered to you, the same day they are gathered. If your doctor approves, give your order to the matron.

"Hot and cold water is available in every room. Distilled ice water is in the corridors.

"You will be conscious of the fact that the members of the staff are only human. They too get tired and cross. All nurses work long hours for a small remuneration and are rewarded by the service to humanity.

"You are one among a number of patients and each nurse is doing her best. You will try to help her in the work she is doing.

"The attached memorandum gives the full details about your fees. All fees must be paid weekly and in advance, please."

The Langton Clinic is the first unit of the New South Wales Hospital for Women and Babies, which is now being erected.

Fifth Hospital Room Is Endowed for Philadelphia Teachers

Philadelphia teachers are the beneficiaries of a fifth hospital room in the Presbyterian Hospital there, according to the *Pennsylvania School Journal.* The endowment of $10,000 was received through the will of Mrs. George H. Stout who provided the endowment in memory of her husband who was for fifty-five years a teacher in the schools of Philadelphia. Mrs. Stout, in her will, directs that "in the use of the room, preference shall always be given to teachers of the city of Philadelphia."

What the Staff's Interest Means to the Hospital

By H. A. ROYSTER, M.D., F.A.C.S.
Surgeon, Rex Hospital and Surgeon-in-Chief, St. Agnes Hospital, Raleigh, N. C.

THE staff's interest in the hospital depends entirely upon the kind of hospital. As far as the staff is concerned, there are four types of hospitals: the private hospital, the closed hospital, the restricted hospital and the open hospital. The private hospital whether it is owned by one man and operated by him exclusively or whether he has associated with him a staff whose members participate in the hospital as a profitable organization, is in a class by itself. In the closed hospital the staff is one in which the entire work is limited usually to a small staff, sometimes to a large one, but with no outside physicians permitted to practice within the hospital. The restricted hospital is one in which a regular staff is appointed and operates but in which other physicians in the community are allowed to practice as a so-called visiting or courtesy staff. Then the open hospital is one that is owned by some board, organization or beneficiary group and that allows all doctors in good standing in the community to practice within its doors.

Where Selfishness Has No Place

Whatever the type of hospital, even as the Sabbath was made for man and not man for the Sabbath, so the staff is made for the hospital and not the hospital for the staff. In other words, the staff is appointed to give service to the hospital, to contribute to its well-being, to minister to its patients. The hospital is not organized for the avowed purpose of making a living for the doctors. Of course, a doctor without a hospital is like a gardener without a garden, but there is gardening for profit and gardening for service. The staff is appointed to serve the hospital. The hospital is not an organization to render a particular service to the physicians, beyond what the physicians can give to the patients. There seems to be a mistaken notion abroad in the land in the minds of a certain number of physicians, who think in terms of what the hospital can do for them. I am always interested in asking those men, "What are you putting into the hospital?" not "What are you getting out of it?"

The standard of existence for the hospital staff is unselfishness. There are times when every member of the staff eases his conscience and is comforted by thinking that his department is the most important in the hospital. Well, no department is more important than any other. No chain is stronger than its weakest link. And in a top-heavy department, which runs ahead of the others, the fault is not with that one, but with the others that fail to keep pace. Unselfishness is the keynote in the efficient hospital staff.

There are three tests of a staff member's interest in the hospital. The first is attendance upon the staff meetings. He may be ever so enthusiastic, ever so interested in the hospital, but unless he attends regularly the services of the staff, he is not greatly interested. The same thing applies to churches, lodges and all organizations. Those who belong and do not attend are barnacles, not boosters.

The second is absolute loyalty. There are men and classes of men who will be found to do their work in the hospital, who, now and then, forget that the hospital work is not set out for their own particular interest and complain both inside and outside of the hospital. I am reminded of a splendid slogan which a laundry used as an advertisement: "If our work pleases you, tell others; if not, tell us." It is much better for the staff member to register a kick in the hospital than to go outside and prove his disloyalty by talking about things in the hospital that do not quite meet with his approval.

When Staff Members Meet Together

The third is efficiency, from the standpoint of the staff member himself, and from the standpoint of aiding and abetting all others on the staff to contribute to that efficiency. If efficiency means anything, it includes not only professional efficiency but personal courtesy and absolute cooperation. It is a term that is often abused. It means to work together.

The staff meeting is not a medical society session. The staff meeting is not for the purpose of

allowing some member of the staff to present a wonderful paper on some difficult case he has had. All contributions to a staff meeting should be with the idea of reporting cases that occur in the hospital, discussions of which will contribute to the efficiency of that hospital and of the staff. No exploitation is to be permitted in the hospital staff. Let one who tries it realize that he is among friends who know him. Exploitation, by the way, is the most sordid and accursed word in the English language.

The Value of Yearly Elections

The staff's interest in the hospital also centers around its relations to the board of managers, the trustees or whoever operates the hospital, its relations to the officials and to the employees and, most important of all, its relations to the patients. In regard to the staff's relations to the board, I think that most hospital organizations are satisfied with the idea of the staff recommending appointments to the hospital. Concerning the recommendations made by the staff for those who are elected by the board, let me say that they should be wedded to the particular idea that the power to elect gives the power to reject. If we are to have efficient hospital staffs, we must have the authority to put men on the staff and also authority vested in the owners of the hospital to put any unworthy person off the staff. I might express it in a more homely way by saying that the power to hire gives the power to fire. Unless we do this, we shall go along for years and years in a species of dry rot, when all the time we might have better men who could take the places of unsatisfactory men on the staff. The best method of doing that is to see that the staff of the hospital is reelected every year on the first of January. Those to be retained are sent a card of a certain color to make it distinctive. Those who are not reelected may be sent a pink card as is done in baseball circles, or else they may be sent none at all. This is the most effective method of controlling the personnel of the staff. This is done in various hospitals, and it works with the entire personnel of the hospital from the superintendent down to the lowest paid help. This is a matter that should deeply concern us all.

There may be among hospital staffs men who are perfectly efficient in their positions, who apparently have the required personality but who are known to be not quite up to par in their behavior to those who are their inferiors in position. Every member of the hospital staff should understand that when a patient comes in the front door, all who have to do with that patient from the time of his admission until the time he is discharged are just as important as he is. And in the work that all members of the hospital organization have to do, if a slip occurs anywhere along the route, from the cook up, discredit must be placed where it belongs.

Then, last of all, there is the relation of the staff to the patient. There is no question of the fact that here is the flower of the whole nosegay, the only reason for the existence of the hospital. The staff members should all work to the same end, to treat the patient professionally and personally so considerately that on his discharge, in as short a time as possible, he will be able to resume his position in the social order. That is the true relation of the staff to the patient; it should be a matter not only of duty but of pleasure. I knew a superintendent who had a painted sign over the arch of the hall inside the door that read: "The object of this hospital is to cure the patient, pleasantly and successfully. Those on the inside who do not subscribe to this, please get out. Those on the outside who do not believe in it, please stay out." I know for a fact that that superintendent carries that slogan in his heart.

The essence of the staff member's obligation to the hospital set forth on a card that was given me by a colleague several years ago contains a quotation from an article by Dr. James Gregory who died in 1828. The quotation, which appeared in the *Edinburgh Medical Journal* in 1862, is headed, "Why We Have Staff Meetings," and reads as follows:

"I do not know, nor can I conceive, any human contrivance that can more effectually and irresistibly oblige the physician to study carefully the case of his patient; to attend to every symptom or change of symptom; to exert himself to the utmost for his patient's relief; and at the same time to be as cautious as possible in the remedies that he employs; than to find himself under the necessity of giving a minute account of everything he has done, in a very public manner, and before a number of competent judges."[1]

Where Musical Concerts Relieve the Tedium of a Hospital Stay

Patients at the Royal Portsmouth Hospital, Portsmouth, England, are helped to forget the tedium of long illnesses through the good offices of the Portsmouth Branch of the Music Teachers' Association which gives a series of concerts once a month to the patients in the wards. Other organizations also give concerts from time to time.

[1]Read before a joint session of the North Carolina and Virginia Hospital Associations, Durham, N. C.

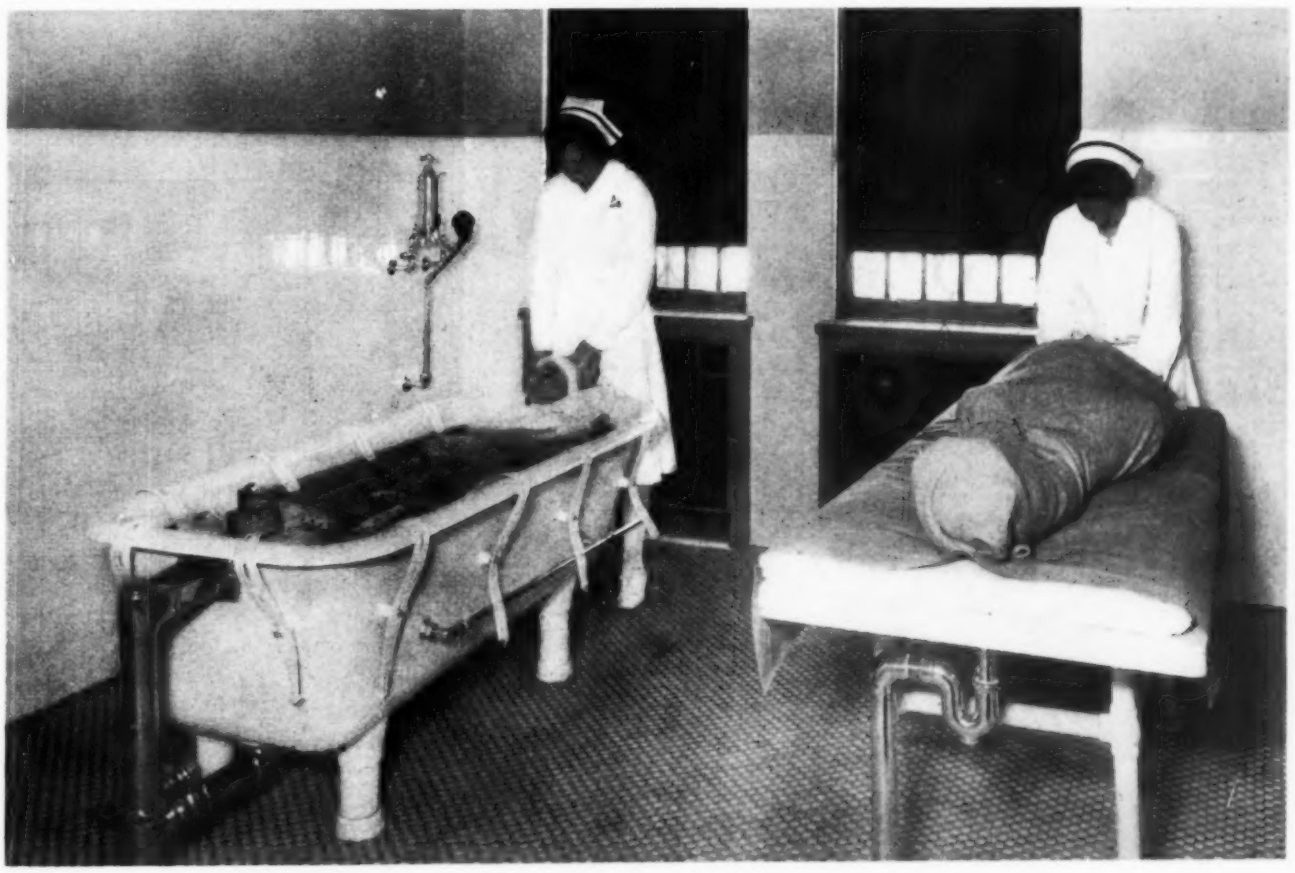
How a State Psychiatric Clinic Treats Early Mental Cases

By M. A. TARUMIANZ, M.D.
Superintendent, Delaware State Hospital, Farnhurst, Del.

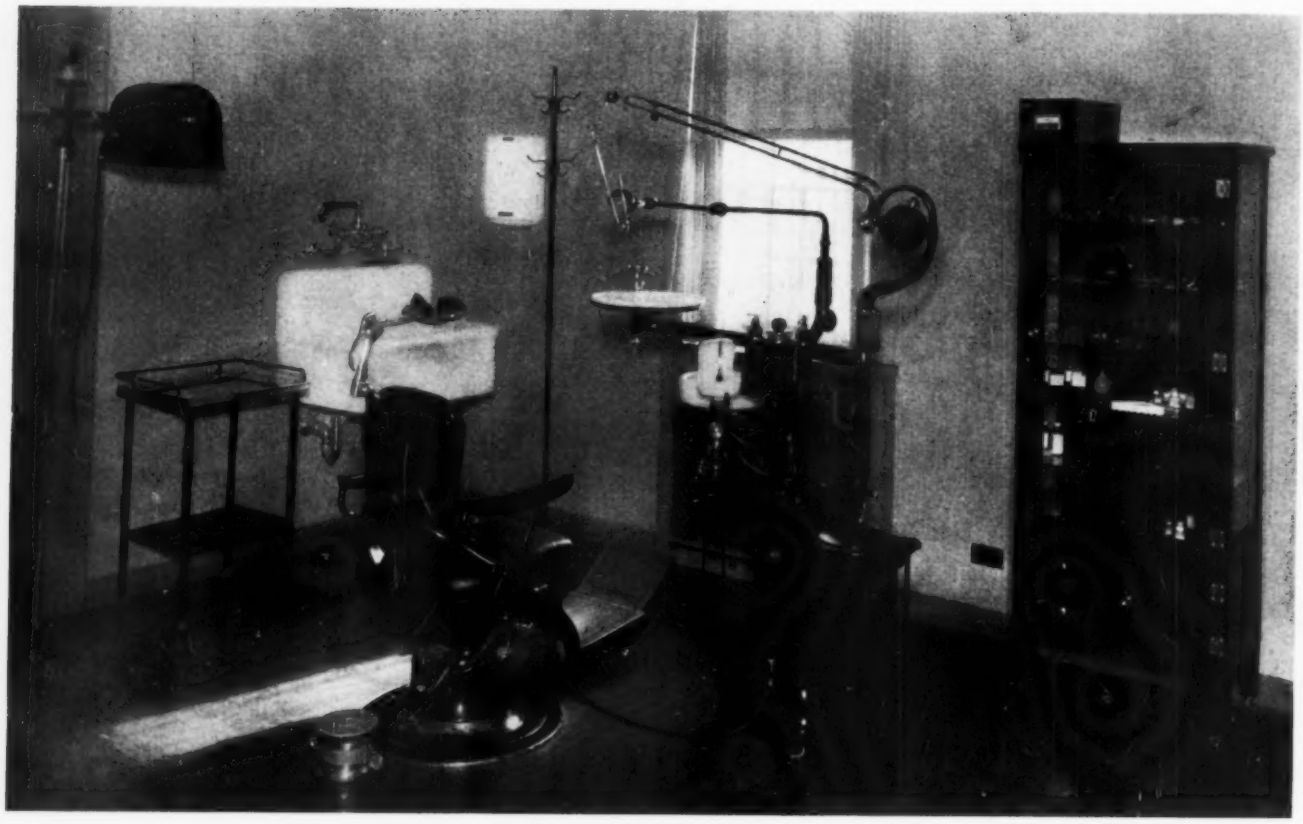
WITH society as cluttered with misfits as it is at the present time, due to our complicated mode of living, the need for psychiatric service to the public is increasing at an alarming rate. At the same time a lack of personnel and funds is making it more and more difficult to give this much needed service.

Since these maladjustments in society are frequently the forerunners of the actual psychotic states, it seems only reasonable that the care of such cases should logically fall under the supervision of the state hospitals. We do not wish to underrate those clinics held by various private and general hospitals. An indirect supervision usually exists since these clinics are often conducted by men who are or have been closely associated with the state hospital. Yet, unfortunately, in spite of these clinics, many of the semi-insane wander into state hospitals for help, due to their ignorance of the existence of such clinics. Also, although there may be many clinics caring for behavior problems in children, those for maladjusted adults are few.

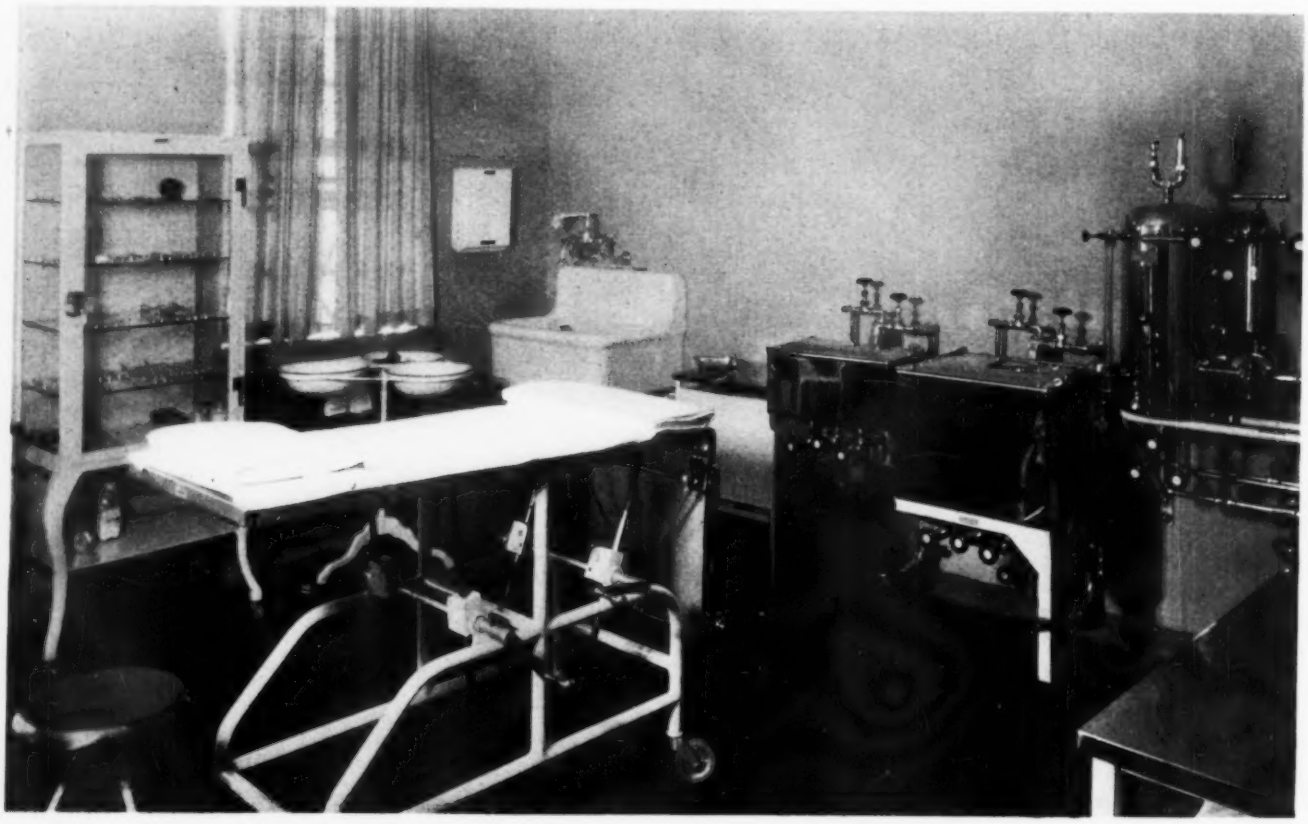
Many years have passed since we lived by the law of the survival of the fittest. Now civilization protects those who are unfit and attempts to strengthen them so that they can successfully compete with those who are inherently strong enough to face the complexities of our modern civilization. Our general hospitals are caring adequately for the physically ill, but it is only comparatively recently that the state hospitals have taken over the burden of caring for maladjustments due to environmental



Here we see one of the two hydrotherapy rooms in the psychiatric clinic.



Recognizing that every medical aid must be provided for the observation and treatment of mental patients, the Delaware State Hospital, Farnhurst, has installed in its psychiatric clinic the most modern dental and surgical equipment. The upper picture shows the dental surgery and the lower, a room for minor operations.



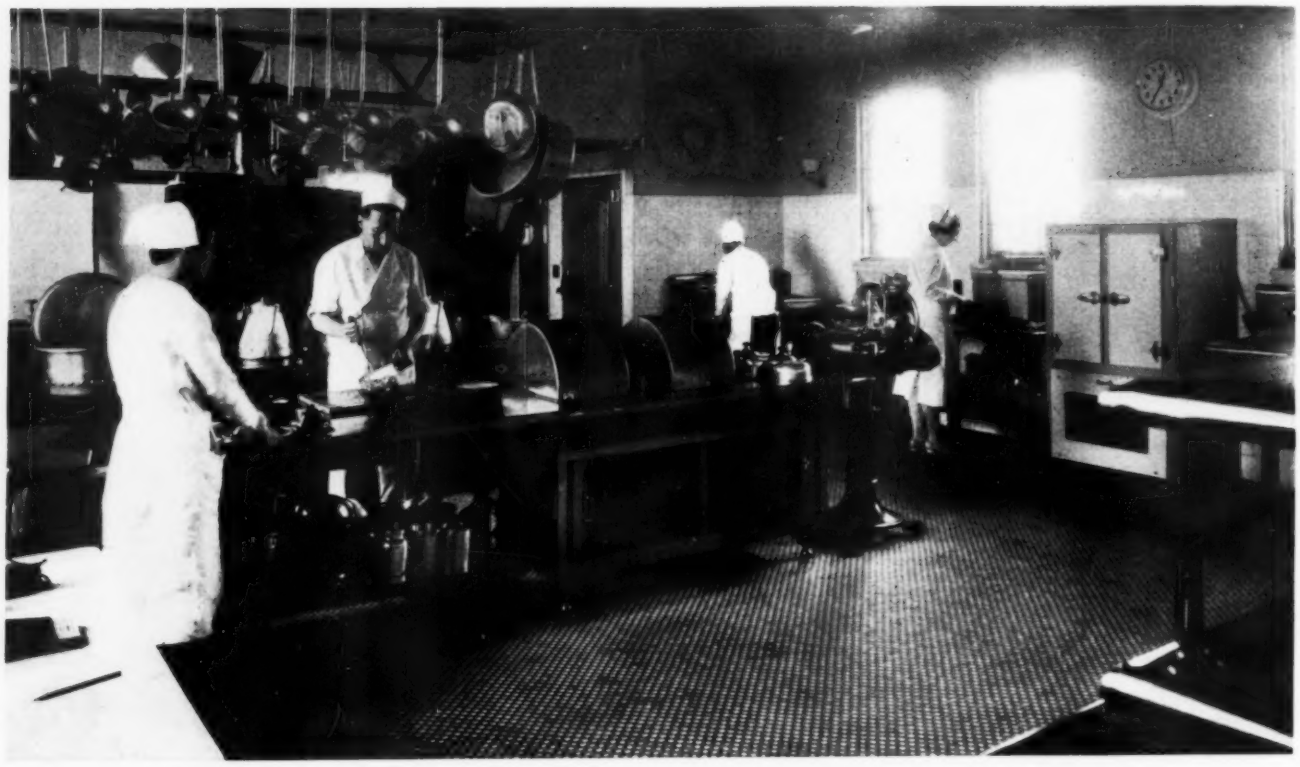
or mental difficulties—those maladjustments that play an important part in the etiology of the psychoses.

Marital difficulty, poverty, crime and inadequacy confront the various social agencies. Behavior problems among school children are a frequent source of difficulty to the teachers as well as to the parents. Since the normal individual does not fight the social order of living, those who are at cross purposes with the world are abnormal to a certain extent. Some of these difficulties are due to environmental causes, many of which can be readily removed. Others are due to an inherent personality defect, about which we know little as yet, but which can be alleviated to some extent by psychic treatment.

This is the attractive type of room provided for the clinic's patients, who though suffering from mental and nervous conditions, are not ill enough to warrant their actual commitment to the state hospital.

Most state hospitals could maintain an out-patient department without materially adding to their staff, yet, unfortunately, few psychiatrists have had much experience with the problems of children. It is only during the last few years that special attention has been paid to this branch of psychiatry. This difficulty is being rapidly overcome, and it will not be long until every institution will maintain a physician on its staff who is qualified to carry on this work. With the marked personality changes in children resulting from encephalitis, even the layman can well recognize that behavior may be closely linked with pathology of the brain tissue. Although by far the greater number of behavior maladjustments are not so closely linked with brain pathology, this serious condition has made us realize that behavior may be beyond the control of the individual. For many years we were inclined to blame him for his actions. Centuries ago it was thought that such an individual was possessed by the devil and could not control his actions. Today we realize that he cannot control his actions, but we have become more scientific. We try to explain his behavior, determine the etiology and remove the cause. The public, which is rapidly being educated to realize these conditions, is demanding clinic care for those of their families who show abnormal trends.

Clinics conducted in connection with state hospitals could serve a twofold purpose, that of caring for the paroled cases as well as offering service to those maladjusted persons who are at large. It would seem advisable for a close interrelation to exist between all of these clinics, since the type of case from which these feed is constantly shifting. Such cases are rather notoriously unstable, ever



The palatable nourishing food prepared here is an important factor in the patients' treatment.

wandering from place to place and causing frequent duplication in efforts to help them. The problem is readily solved in a small state where the entire work can be carried on by a single unit under the control of a state hospital which cares for the entire state. A considerable amount of confusion is thus avoided and contact is readily kept with all patients as long as they remain residents of the state. The same clinic gives service to the various penal institutions as well as to the more or less private organizations which care for the dependent. With this rather broad scope of work, the ultimate adjustment of cases can be readily obtained and their progress carefully checked.

Another important factor to be considered in having such a clinic maintained by the state is the question of finances. State control removes all seeking of funds from private sources and allows the clinic to spend its entire energy on the more important factors, those pertaining directly to the patient.

The education of the public is an important duty in the working of a successful clinic. It is only human to expect immediate results. The public does not realize that the pathological condition existing has taken years to develop and that it cannot be rectified in a short time, that it will take months and even years before satisfactory results can be obtained. This idea exists not only in the public mind but frequently in the minds of trained workers who bring the patients to the clinic to be examined. Their problems are difficult and naturally they desire a quick adjustment. Delay often results in a loss of contact between the workers and the clinic, unless the workers fully understand the complexity of the problem involved. Also with their small understanding of psychic problems, the information they bring to the clinic about the patients is inadequate and throws a further burden on the clinic personnel. Until the nature of behavior cases and the early signs of semi-insanity are understood, these workers are unable to obtain the information necessary to the successful handling of a case in the clinic.

How the Clinic Serves the State

At the present, the psychiatrist is frequently forced to make a recommendation without the proper information. This is an unfortunate and even dangerous procedure, often resulting in dismal failure. In later years the necessary training will be a part of the schooling of every worker. Until then, it is part of the burden of the clinic to help in the education of the workers outside of its own personnel, preparing them to help in the ultimate adjustment of the individual case.

For this reason the mental hygiene clinic in Delaware has on its staff an experienced physician and psychiatrist who has had years of experience with abnormal children. This person, working only part time it is true, spends this time in purely

educational work. Not only does he instruct professional workers regarding the more technical work, but he also lectures to various groups regarding mental health in general. In addition he keeps the public informed as to the type of service the clinic gives.

The work of a single clinic in a small state becomes diverse in character. In addition to the special problem cases and to cases in institutions, service is given to schools where retardation and class placement are important factors. This clinic also offers service to persons of all ages so that it is not an infrequent occurrence to have entire families brought for study. It also controls the sterilization of all cases that are at large: those who are mentally deficient, those who are epileptic and those who have been convicted of three or more felonies, whose behavior is due to abnormal personality make-up.[1] The clinic makes the preliminary examination and refers to the proper authorities those cases recommended for sterilization.

As yet the parole cases have not come under the care of this clinic but they will be gradually absorbed as the personnel increases. This will obviate the necessity for paroled patients who live at a great distance from the hospital to travel a long way for treatment. The hospital staff will thus have a more frequent contact with the out-patients of the hospital and an opportunity to carry through predischarge psychiatric examination. Up to this time it has been found necessary to depend on information obtained from social workers which has at times resulted in the recommitment of patients shortly after they have been discharged.

Special Attention to Borderline Cases

When a state controlled mental hygiene clinic was contemplated for Delaware, careful consideration was given to borderline cases who need more careful and continuous study than can be given at a clinic. Many persons suffering from these borderline conditions react well to a hospital residence of a short period where they can receive daily psychic treatment. Other actual psychoses of a few days' duration could well do without actual commitment to a state hospital if there were some institution in which they could stay. With such patients in mind, Delaware built a psychiatric observation clinic, the purpose of which was to provide hospital residence for patients suffering from mental and nervous conditions which did not warrant their actual commitment to a state hospital.

This institution, under the control of the same board that controls the state hospital, has proved successful. Several of the patients after a short residence have returned to useful positions in society. Others have reacted well to the treatment received, both physical and mental, and have been prevented from developing an actual psychosis. This institution takes only the cases that are referred by the family physician. It is equipped to care for any type of patient.

As to the personnel of the organization that cares for these borderline cases, intensive training is, of course, essential. With the ever increasing interest in mental life, more and more emphasis is being placed on this, and few institutions make the mistake of appointing individuals not adequately trained. Personality plays a much greater part in the treatment of these borderline cases than it does in that of the actually psychotic. Many well trained physicians have failed because of some personality defect that has made cooperation with the patient difficult. Furthermore, all persons who come in contact with the patients must themselves be perfectly normal, mentally. It is remarkable how many psychopathic and neurotic individuals attempt to work with the mentally abnormal.

[1]Laws of Delaware, vol. 36, chap. 245, p. 740.

Increased Service Given by Six Rural Community Hospitals

The six small hospitals built with the aid of the Commonwealth Fund, in Farmington, Me., Farmville, Va., Murfreesboro, Tenn., Glasgow, Ky., Wauseon, Ohio, and Beloit, Kan., operated at local expense, have been called upon for 12 per cent more service this year than last, says the fund's annual report for 1931. The financial policies and administration of these six community hospitals have been strengthened and plans for out-patient service have been developed.

This program was begun in 1925 in view of the fact that more than half of the counties in the United States had no general hospital for the care of the sick, and that medical service in rural areas was gradually decreasing. "The rural hospital program," the report states, "has been an experiment to determine how the hospital of modest size can best contribute to the improvement of health service in the small town and open country. Through the hospital, if its function is broadly defined and its work is flexibly directed, a sheaf of educational influences can be brought to bear upon both physician and layman which, in the long run, may revolutionize the philosophy of rural medicine and the practice of community health.

"It is possible to say with assurance that in every one of these six communities the hospital is meeting a definite need and is growing in public and medical favor."

Practical Administrative Problems:

How Economies May Be Effected in the Hospital Pharmacy

A SERIES of articles previously printed in this magazine dealt with methods by which money could be saved in the conduct of a hospital. It was the intention at that time to describe in detail economies that if practiced would not result in lessening the efficiency of the hospital, but would make it possible to render an adequate service at less cost. Following this series there were printed a number of articles dealing with methods by which the income of the hospital might be increased.

Because of the present pressing economic need most institutions have judiciously endeavored to increase their incomes without unduly embarrassing their clientele. In most localities it has not been thought a wise policy to endeavor to add any new items to the already unduly large list of special charges nor has it been considered either feasible or fair to increase the room rates in effect in the past.

When Retrenchment Is Necessary

It is the purpose at this time to review in a shorter series of articles methods by which the hospital may save money. New suggestions will be added and the text of previous articles will be condensed so as to facilitate their perusal.

The question of hospital economy cannot be too greatly stressed and it appears an act of wisdom for the administrator frequently to visé all of his institutional expenditures in order to make certain that no further savings consonant with good service can be brought about. It will be recalled that the functioning and the expense incident to the pharmacy, the dietetic department, the school for nurses, the operating suite, the storehouse and other major departments were discussed. It is the purpose of the present article again to describe methods by which savings may be brought about in the purchasing, dispensing and storing of drugs and chemicals.

The pharmacy presents problems peculiar to itself in that charged to its account are usually found many drugs and chemicals not utilized for administration *per orem* but employed as antiseptics or disinfectants or for one of many other miscellaneous purposes in and about the hospital. Moreover, this department cannot be expected to show a balance sheet on which income in any way aproximates expense.

Many hospitals have endeavored to reverse the usual balance sheet findings by realizing a profit from the sale of the drugs and incidentals commonly dispensed in the community commercial pharmacy. It is a policy of questionable wisdom to require the average hospital drug store to function as a purchasing and supply agent in providing pharmaceuticals and materials not directly concerned with the actual treatment of patients. Gauze, cotton, adhesive plaster, glassware, oxygen, nitrous oxide, ether, rubber goods and many other similar necessary articles and supplies are frequently purchased by the pharmacist. The carrying out of this policy requires much of the druggist's time, and efficiency of purchase is not always thus guaranteed because he is usually not trained to buy this type of supplies. The purchase of alcohol requires an annual expenditure of a large amount of money. Antiseptics and similar chemicals are necessary for the conduct of a hospital but are materials from which no income can be produced.

To levy a special charge upon private patients for drugs used in routine treatment is a plan that is likely to create dissatisfaction. A patient must possess an unusual amount of self-restraint and evenness of disposition unprotestingly to pay a fee of but a few cents for a laxative or for some other common remedy in addition to the ten or fifteen dollars a day he is paying for his room.

One Way to Meet the Situation

The surest remedy for this difficulty is the establishment of a flat rate covering all services. Many hospitals have been able to put this plan into successful operation. Most hospital statistics do not endeavor to set down any cost per capita for drugs. Indeed, there are no reliable statistics available covering this figure. In most institutional accounting statements, medical and surgical supplies are grouped together, the drug itemization not having been worked out. It is because of this fact that the administrator has become accustomed blindly and

unquestioningly to purchase all drugs that are requisitioned. It is not surprising, therefore, to observe pharmacy shelves and storerooms cluttered with expensive preparations no longer popular and rarely prescribed. It is evident, therefore, that while minor additions may be made to the income of the hospital derived from the sale of drugs to private, semiprivate, ward and dispensary patients, little major financial relief can be expected from this source. Hence, it becomes all the more necessary for money to be earned through saving in expenditures.

Hospital Pharmacy or Drug Store?

The foregoing statement is made with a full knowledge that to meet this situation many hospitals have felt it wise and necessary to conduct their pharmacies somewhat on the plan of commercial drug stores. In some instances, it is difficult for the uninformed to be certain that he has not entered a street corner pharmacy when he looks about the hospital drug department. Here are displayed rubber goods, the newest novel, confections, flowers, stationery and even in some instances medicines of doubtful origin. The location of the hospital and the general methods by which it is financed will determine the advisability of such a plan. There are many, however, who believe that the function of the hospital drug store is to supply to private patients pure pharmaceuticals at a price but slightly in excess of their cost to the hospital and that to compete with near-by community stores in the sale of novelties and standard hospital supplies is not a wise scheme. It has been stated by those of this mind that if it is proper to sell to the public all types of drug sundries and miscellaneous preparations, such as perfume and books, that, *reductio ad absurdum*, the hospital might also dispense sugar, flour and potatoes at a profit.

From the standpoint of saving money, the hospital executive should carefully scrutinize the origins of the demands for drugs, particularly in the free wards. The starting point for economy or extravagance in the handling of drugs is at the patient's bedside. Almost daily high pressure salesmanship brings to the doctor's attention new preparations for which the most extravagant claims are made. The most inexpensive and commonly understood drugs, when adorned with unusual containers, attractive labels and pleasing flavoring extracts, with a name that captures the eye and the imagination of the physician, become an extravagance the hospital can ill afford. When chemically analyzed many such new preparations are found to contain but common drugs labeled with a copyright name describing the whole. It is a wise plan for the executive to scrutinize the list of persons in his institution for whom single drugs or those combined in prescriptions are supplied free. It is wise also to endeavor to control, in the case of ward patients particularly, the practice of prescribing drugs in combination rather than permitting the nurse to administer these agents from her ward closet.

The relationship between the central pharmacy and its substations, the ward medicine closets. should also be carefully examined. Many thousands of dollars may be easily lost by the hospital that does not closely check drug requisitions forwarded by floor supervisors. Ineffective and careless ordering on the part of these supervisors usually without any administrative visé may result in the accumulation on each floor of a great number of drugs deteriorating with age.

The methods by which inventories are taken and drugs are stored should also be scrutinized by the executive and, finally, a revision of the policies employed in the purchase of drugs offers many possibilities for economy frequently not taken advantage of.

Many statements have been made in articles in this department in the past concerning the necessity for preparing a list of drugs permissible for use in the treatment of ward patients. Those remedies contained in the United States Pharmacopeia with some additions from the list set down in "New and Nonofficial Remedies" published by the American Medical Association usually offer enough variety for the treatment of almost any medical condition. The average physician, however, is not willing to limit the number of drugs he uses to these lists, ample as they seem to many. He has been circularized or perhaps visited by a representative of a pharmaceutical house concerning some new and supposedly more efficacious remedy in a concentrated form. Almost daily there flashes on the pharmaceutical horizon some new preparation of cod liver oil, liver extract, digitalis, or a new biologic or tissue product. The physician feels not only that the patients in his ward service should receive the benefit of these new discoveries but also that his experience, *pari passu*, should be widened by their use.

Saving on Digitalis

Not only is this seeker after the therapeutically new commonly a member of our hospital staffs, but the polypharmacist is still conspicuous by his presence among all groups of physicians. Is there any reason why, for example, at least a dozen preparations of digitalis should be necessary for the treatment of ward patients? Digitalis, whether in liquid or in dry form, varies in cost from approximately one cent for twelve doses of 10 minims each

of the tincture, to twelve and one-half cents for a 1 cubic centimeter ampule of a product for intravenous or subcutaneous use. In other words, in this instance a good tincture costs approximately 1/130 as much as a preparation in ampules which is suitable for hypodermic use. A therapeutically active preparation of the dry leaf costs approximately one-half cent for a dose, which is equivalent to 1 cubic centimeter of the liquid form. The product of another firm, not proper for hypodermic use but to be administered *per orem,* costs sixty cents per ounce at the hospital price or approximately two cents a dose. The same preparation in ampule form costs five cents an ampule of 1 cubic centimeter. In one hospital, no less than eleven different types of digitalis are in use. These vary in cost from the tincture at approximately ten doses for one cent to a high grade ampule for hypodermic use that costs twelve cents. What an example of wasted money! How senseless is such blind belief in and adherence to the claims of pharmaceutical houses which contend that some new powerful glucoside is now resident in their special preparation of foxglove. No wonder the public looks with critical eye on such a system of prescribing.

Confusion Reigns

Would it not be safe and economical to require that only one good preparation of the dried leaf and one liquid preparation for hypodermic use in addition to an active tincture shall be prescribed for ward patients? To digitalize a patient of average weight by employing the product in ampule form would cost from two dollars to two dollars and fifty cents. In employing the tincture the cost would range from four to six cents. If the leaves were employed, the same result might be brought about by the expenditure of from fifteen to twenty cents. Enough has been written to demonstrate the confusion that now exists in most hospitals in regard to the use of such a common drug as digitalis.

There is almost the same need for a clarification of the therapeutic indications in the use of cod liver oil and the vitamins as there is in the use of digitalis. Some new form of vitamin therapy appears almost daily. The oily extract from a variety of fishes is said to be more efficacious than that from the lowly cod. Efforts at concentration and at reducing the size of the dose and at increasing the efficiency of these agents have been responsible for the large number of new preparations that have flooded the market. The executive has either to turn a deaf ear to these new drugs or helplessly to purchase all that are suggested. He is between the Scylla of incurring expenses that the hospital cannot meet and the Charybdis of taking upon himself the responsibility for not procuring the drugs the doctor requests. The executive committee of the staff is his only hope. If some rational solution cannot be brought forward by this committee, the superintendent is far from solving his problem.

The compounding of drugs in smaller quantities for ward service if prescriptions must be employed is another method of saving. Frequently the intern (and the young physician is usually permitted to write prescriptions with the greatest abandon) orders a 3-ounce mixture, a dram to be given at each dose. This is sufficient for a week of treatment if the usual three times a day frequency is followed. Should the patient become nauseated or if for some other reason another drug is employed, the whole prescription must be discarded. For example a prescription for a simple cough mixture follows:

℞
Codeine sulphate, gr. VI
Ammonium chloride, dr. IV
Mist. glych. co., oz. III
Sig. A teaspoonful every three hours.

Such a prescription may be administered but two or three times, the condition of the patient changing or the preparation not being well received and the hospital suffers the loss of not only the time required to compound the prescription, but also of the drugs used as its ingredients. Such a prescription as the one given may be written in 2-ounce quantities or even possibly compounded on the ward. There is no particular reason why these ingredients should not be administered separately. The proper supervision of the ward medicine closet by the institutional druggist is of the greatest importance. Weekly inspections should be made and unused drugs returned to the central pharmacy. If the stock is thus kept fresh unnecessary deterioration will be avoided. The proper labeling of ward medicine closet containers should be under the direction of the pharmacist. When he observes evident extravagance on the part of the nurse, the attention of the superintendent should be called to it.

Purchasing Drugs in Larger Quantities

Much can be said in regard to the purchase of drugs. Competition should be sought, and prices submitted on standard drugs by reputable houses are likely to vary from 10 to 25 per cent when bid sheets are circularized and a healthy competition is thus created. The purchase of drugs in quantities sufficient to last one or more months is financially advisable. Care of course must be taken to avoid the purchase of drugs in quantities that will bring about loss by deterioration. Some examples

of the advantage of purchasing drugs in larger quantities are shown in the following list.

Liq. cresolis compound	$1.05 a gal.	(2 to 5-gal. quantity)
Liq. cresolis compound	0.95 a gal.	(50-gal. quantity)
Sulphur ointment	$0.05 a lb.	(10-lb. quantity)
Sulphur ointment	0.04 a lb.	(25-lb. quantity)
Boric acid ointment	$0.30 a lb.	(25-lb. quantity)
Boric acid ointment	0.26 a lb.	(50-lb. quantity)
Hydrogen peroxide	$0.06 a lb.	(38-lb. quantity)
Hydrogen peroxide	0.05½ a lb.	(90-lb. quantity)
Iodine, resublimed	$4.95 a lb.	(1-lb. quantity)
Iodine, resublimed	4.75 a lb.	(5-lb. quantity)
Sodium bromide	$0.37 a lb.	(20-lb. quantity)
Sodium bromide	0.33 a lb.	(25-lb. quantity)
Potassium citrate	$0.51½ a lb.	(2 to 5-lb. quantity)
Potassium citrate	0.47½ a lb.	(25-lb. quantity)
Sodium phosphate	$0.15 a lb.	(5-lb. quantity)
Sodium phosphate	0.11 a lb.	(25-lb. quantity)
Sodium sulphate	$0.14 a lb.	(5-lb. quantity)
Sodium sulphate	0.10 a lb.	(25-lb. quantity)
Theobromine sodiosalicylate	$2.30 a lb.	(2-lb. quantity)
Theobromine sodiosalicylate	2.17 a lb.	(5-lb. quantity)
Santal oil capsules	$5.40 a C.	(300-capsule-quantity)
Santal oil capsules	3.60 a C.	(500-capsule-quantity)
Codeine sulphate	$8.57 an oz.	(2-oz. quantity)
Codeine sulphate	8.50 an oz.	(5-oz. quantity)
Glycerin	$0.13¾ a lb.	(50-lb. quantity)
Glycerin	0.13¼ a lb.	(100-lb. quantity)
Glycerin	0.12¾ a lb.	(500-lb. quantity)
Sodium iodide	$4.41 a lb.	(3-lb. quantity)
Sodium iodide	4.37 a lb.	(5-lb. quantity)
Quinine dihydrobromide	$0.62 an oz.	(1-oz. quantity)
Quinine dihydrobromide	0.56 an oz.	(5-oz. quantity)
Antuitrin ampules	$0.85 a box of 6	($13.88 for 96 amp.)
Antuitrin ampules	9.78 a box of 100 ampules	

The institution that is not endeavoring to buy its drugs on bid is missing an opportunity of saving a substantial sum of money. Glucose ampules, arsphenamine and sometimes insulin and liver extract can be purchased at an advantageous price if larger quantities are bought. Of course, the greatest expense to the hospital lies in the purchase of such remedies as antimeningococcic serum, antistreptococcic serum, erysipelas serum and other biologic preparations. These remedies cost from five dollars to seven dollars and fifty cents per dose and in the course of the year the sum spent for them mounts into the hundreds or even thousands of dollars. The hospital cannot economize on these drugs. On the other hand, frequently relatives or friends of the patients treated should rightfully make an effort to meet some of the expense which the hospital experiences in treating these patients.

In regard to the use of proprietary medicines, much can be said. There is a type of physician who greatly enjoys the gasps of astonishment and wonder that arise from the interns and nurses when a new and complicated drug is prescribed. Unless sound therapeutic reasons lie behind such a prescription, the gasps of the board of directors when confronted with the statement of the cost should more than offset the satisfaction of the chief in ordering a new remedy. Such a visiting physician is often a liability rather than an asset to the hospital. Many of the men of the older school believe that almost every condition likely to be met can be successfully treated from a drug standpoint even if they were given but a dozen remedies from which to prescribe.

Finally, the executive of the hospital, unless he spends some time each week in consultation with his druggist and in the inspection of his drug stock will lose many an opportunity to economize on his drug bill. The use of oxygen in large tanks, the purchase of drugs in moderately large quantities, the suppression of polypharmacy, the simplification of ward prescribing by use of a formulary, the prevention of the prescribing of expensive drugs in the dispensary—all are basically necessary if economy is to be brought about.

Community Hospital Plan Is Urged for New York City

New York City's hospital bill is more than one million dollars a week, according to Homer Wickenden, general director, United Hospital Fund of New York.

Approximately 60 per cent of the annual total of $57,200,000 spent by the hospitals is for the treatment of patients unable to pay, and this part of the expense must be found in taxes, donations and legacies.

Pointing out that the hospital service of New York City is a gigantic business subject to the economic influences and fluctuations of every big business, Mr. Wickenden says it is still largely unplanned. A community hospital plan is urgently needed.

"New York has a hospital investment of over $200,000,000," he says, "but notwithstanding the work of coordination done by the United Hospital Fund, and that performed by the State Department of Social Welfare, the City Department of Hospitals and the various conferences of hospital superintendents, the metropolis still lacks a hospital plan."

He thinks that in order to assure the maximum service at a minimum cost to the public, New York should follow the examples set by Cincinnati, Louisville, Ky., Cleveland, by Newark and Essex County, N. J., and other large cities in establishing hospital councils for the purpose of effective community planning.

Editorials

Contracts for Superintendents

AN INTERESTING point was raised at a recent state meeting that gives much food for thought for the entire field. A question was asked regarding the desirability of hospital superintendents entering into written contracts with the hospital. Without exception those present agreed that written contracts for the incoming superintendent were not only desirable but most beneficial for both the superintendent and the hospital.

Three-year contracts seemed to be the rule and often these were renewed in writing but not in every case. One superintendent stated that at the end of the three-year period her board offered her another written contract but she felt that she knew her community well enough to go along from year to year. She has been in this same place now for more than six years. Another superintendent states that his contract was written and ran for three years with a six months' clause that could be exercised by either party.

There is no question of the desirability of the written contract and there is plenty of precedent for it. No superintendent can do his best work when he is called upon almost daily to play politics and justify his position. Few superintendents can make the necessary showing in less than three years and a man should be left to work out his position unhampered by fears or worries or false ideas of diplomacy. On the other hand, boards of trustees would be a little more careful in hiring superintendents if written contacts were demanded. There would be a decrease in turnover, and gradually those superintendents who either leave positions or are asked to leave them would be eliminated from the field.

Vacation Policies

TOO often, vacation lists for hospital workers are formulated on the ground of personal attributes that have no concrete basis of evaluation. To be sure, length of service and loyalty to an institution are commendable traits worthy of reward. But to extend a vacation leave of absence for one individual beyond the time allowed to others of the same group is to court dissatisfaction and friction which augurs ill to the morale of the hospital.

Tradition seems to have fixed the time of vacation for supervisory nurses, social service workers and others of this type and rank at four weeks, while clerks, telephone operators and technicians are usually granted but half this time away from the hospital. If there is a logical basis for this diversity of vacation time permissions, let no exception be made in the case of any member of each class. Moreover, it would appear that a definite statement should be set down as to the holidays upon which certain hospital workers are excused from work and that only rare exceptions should be made to this rule. Favoritism or any evidence of special privilege should be assiduously avoided in dealing with the members of the hospital's personnel. No hospital should long continue to function without a carefully formulated vacation policy.

Standing Orders

HOSPITALS that treat patients en masse clinically as well as administratively (there may be some excuse for the latter, but there is none for the former) are readily identified by various distinguishing practices in their wards. One of the most pernicious of these is the custom of the visiting staff, which is rapidly imitated by the resident staff, of issuing an uncontrolled "Standing Order" for the treatment of a patient.

During the limited time at his disposal, the visiting physician feels that he must select for special consideration those "cases" on the wards for whom he thinks that his talents can produce the best results. For these patients there is enough individualization (as there is in private practice) to guarantee, for a time at least, enough attention to the prescription of drugs and to the study of their effects. For the others, however, of whom the chronic are a good example, there is a hurried word, with the inevitable "Standing Order," "s. o. s.," or "p. r. n.," leaving it to the nurse in attendance to decide when a drug, often very potent, may be administered. These orders may be for regular daily doses over long periods of time, or for occasional doses to meet certain signs and symptoms as interpreted by the staff nearest the bedside.

That there is enough justification for the "s. o. s." and "p. r. n." practice with certain patients, under certain circumstances, cannot be denied, but the habit of indiscriminate prescription without adequate control before, during and after the administration of a drug, can only be condemned as subversive of good medical practice. The right to prescribe involves the obligation to

follow up. It might be asking too much to expect an accurate check-up of every last dose of medicine given, but such an ideal state of affairs should at least be approximated more frequently than seems to be the case at present.

One large hospital in the East recently had an experience with patients suffering from cardiac edema, who had been treated in the large public ward with the usual uncontrolled doses of diet, digitalis and other medication. A group of these patients was transferred to a small observation research ward where every dose could be watched and the results scientifically tabulated. Within a few days some of these patients lost as much as forty pounds of fluid, which were quickly regained by transfer to the large ward where observation of their condition was of the usual casual nature. Hospitals may not be able to afford highly specialized and intensive medical attention for every ward patient, but on the other hand, they can avoid certain practices that are known to possess vicious possibilities.

Here is a suggestion that might be placed on the agenda for the much desired meeting of the administrator with the medical board, a pleasure which no administrator can afford to deny himself. Medical men who enjoy staff privileges have administrative as well as clinical responsibilities.

Light Ahead for Hospitals

SINCE that famous autumn day in 1929 when stocks began to slump and business began to go down hill, there have arisen in this country more false prophets than have graced this old world in all the centuries of which we have any account. One hesitates to predict good times even when all indications point in that direction, but we are sure that one more guess will not harm.

It is reported by the employment and placement agencies serving the hospital field that there has been an increased call for help during the past thirty days and that more hospital department heads have been placed than for some few months. It is further reported in the state of Pennsylvania that there is an increase in occupancy and that this increase does not mean more free patients but more pay patients. In Iowa, collections are better. Building programs are planned in both Pennsylvania and Texas, the only two states that have so far been economically surveyed as to their hospital conditions. Salesmen for hospital supply houses report that there has been an increased business in Illinois, Wisconsin, Iowa and Indiana and that while collections are still slow there is light ahead. Manufacturers and distributors of oxygen tents claim that there is a little boom in this line and food distributors say that conditions are encouraging.

Campaigners for additional funds for the hospitals are not optimistic for the immediate future but all of them have laid their battle lines and are ready to start on a moment's notice, and it is believed that the public will respond almost as well as they did in those good old days of hysteria. Perhaps the condition is temporary but most people think that it is not. Hospitals generally have weathered the storm and come out smiling. They have been called upon for more free work than ever before, they have had less money to operate with, yet they have come through in great shape and will continue to prosper when the clouds have rolled away and the sun of prosperity once again beams down upon all of us.

Ghoulish Politicians

IT SEEMS that one of our largest cities is about to disgrace itself again. County commissioners scent handouts ahead in connection with a building program; so the "head crucifier" has turned upon the directress of nursing who is counted among the best in the country, and it looks at this writing as if her scalp was in the war bag, leaving the way clear for the county commissioners to do the purchasing for the new nurses' home.

The city referred to has a most unsavory reputation for graft, and while the pockets of the politicians are still well filled with ill-gotten gains, the patients in the hospital wear unbelievably shoddy pajamas and the death rate has long been the scandal of the medical profession. Fifty-bed wards, cruel treatment, high death rates and swinish politicians complete an already filthy picture. We hope that some day decency will reign and that thorough investigations of conditions in this institution and others of its kind will be made so that the poor will at least get adequate care for the money appropriated, which is not the case at the present time.

What Is a Hospital?

THE public is slow to learn the meaning of the term "hospital." To many persons, a collection of beds and sufficient floor space to allow more or less adequately for their somewhat orderly arrangement, and an indefinite number of physicians and nurses supposedly possessed of the necessary professional preparation, justify the announcement that a new hospital has been born and that the sick will be received and proper treatment given them.

But beds do not make hospitals, nor is the presence of doctors and nurses and sterilizers and operating rooms a guarantee that a hospital exists in the true sense of the word. Through the medium of education the public is learning all too slowly that buildings and beds can be easily appraised as to whether they are fitted to their proclaimed purpose, but that the skill, ethics and honesty of persons are much more difficult to evaluate accurately.

It would be a fine service to the sick of this and future generations if legal requirements could be formulated to restrict the use of this term to worthy institutions only. Perhaps some such plan of state licensing could be evolved for the general hospital as is now the case in institutions for the care of the mentally ill. It is not improbable that a slow but certain economic evolution of institutions will compel those hospitals impoverished both in money and personnel to give way to those that are economically more fortunate. It is highly to be desired that only those institutions will long survive the test of today's standard of service requirements which can provide a complete and adequate equipment in plant and personnel. The public deserves and soon will more often demand to know how it may differentiate between the true and the false—between the safe and the scientifically careless and imperfect hospital.

Silence Is Golden

TO LISTEN much and talk little is a difficult lesson for young physicians and nurses to learn. Too often, however, even those of greater experience spread fear and distrust in the hearts of the relatives of patients by unwary acts or expressions.

A nurse who has not learned to avoid answering direct questions as to the diagnosis and treatment of the patient for whom she is caring is a danger to the peace of mind of many persons. To criticize the doctor deliberately or by gesture or cast of countenance to infer that all is not well with the treatment of the patient should place the guilty individual beyond the professional pale. Such a nurse is not loyal to the patient, to the doctor or to herself. She is little better than that tactless one who vouchsafes the information that Wassermann reactions are positive or that some hidden factor in the history is being suppressed. The well-being of the patient and the reputation of the doctor are without exception unsafe in the hands of the garrulous nurse. Fortunately this type of person is in the minority. As soon as the executive learns of her existence in his institution, he should with dispatch separate her from the organization.

The Adhesive Habit

THOSE administrators who are in sympathy with the therapeutic nihilist who believes that many drugs prescribed for patients are wasted anyway and that some do more harm than good, might take comfort in the thought that waste, after all, is more or less universal (depending on the efficiency of supervision and control, and the cooperativeness of patients and personnel) and may, like the poor, always be with us. Take, for example, the uses of all kinds of hospital equipment for purposes other than those for which they were purchased and the waste of money that results.

One need not go to the extreme of the picture and cite instances where members of the house staff are discovered using delicate eye instruments for manicuring purposes. The most universal and perhaps the most insidious example of waste in the hospital may be found in the illicit uses to which adhesive plaster is put. It is employed by the thoughtless (regardless of the cost to the hospital) as a convenient ideal binding material that possesses virtues, especially during holiday gift seasons, far greater than wrapping cord, which is often flimsy and elusive and lacking in that confidential appearance, and security, which some form of adhesive tape alone can give. It will stick to anything but benzine, and its use is therefore not limited to the human body. It is tenacious, has staying power and, although it often leaves an ugly reminder of its use, is not in the ordinary sense painful to remove from inanimate objects.

If a notice is to be posted (bulletin boards not yet having come into universal vogue) what will hold the sheet more firmly in place than those ubiquitous strips of adhesive? It will repair broken furniture, bridge over gaps in equipment and unite severed fragments. It will stop leaks for a time, serve to suspend objects from a height and prevent other objects from rising off the floor. It will hold anything down but the item of expense. Its power as an insulator is well known and it can therefore be used to cover exposed wiring. It will even hold an intern's uniform together—till it reaches the laundry.

But it is not only the misuse of adhesive plaster that wastes the pennies. Every hospital administrator indeed knows that much may be saved if only the personnel and the patients will be cured of a disposition to regard hospital equipment as public property, to which people may help themselves without rendering account to a generous contributing public. If water, steam, gas and electric current could be conserved for legitimate uses only, what a saving there would be for more worthy purposes!

NURSING AND THE HOSPITAL

Conducted by M. HELENA MCMILLAN, R.N.
Director, School of Nursing, Presbyterian Hospital, Chicago

Budgeting Leisure Time

By ROBERT M. PARKS
Educational Adviser, Home Study Department, Columbia University

LIFE for all of us is more or less a battle against time. What we do with our time, how we budget our hours, largely determines how far we shall progress toward our goal, whether our goal is the rendering of more service to our community, the making of more money, the winning and holding of more friends, or whatever objective or combination of objectives we may set up for ourselves.

A great deal has been said and written about financial budgets, much more than about time budgets. It seems to me, however, that it is just as important if not more so that we budget our hours as that we budget our dollars. Some of us may not have so many dollars to budget, but we all have precisely the same number of hours each day for budget purposes.

The great life insurance business is based on mortality tables covering thousands of lives, on a budgeting of lifetimes. In effect, the life insurance companies bet us at so much a premium per thousand dollars of insurance that we shall live, and pay premiums, a certain number of years.

A Paying Investment

The dollars we invest in life insurance premiums are for the benefit of our heirs, unless the policy is an endowment policy, payable to us as an old age safeguard. It seems to me that the real life insurance, which we do not have to die to cash in on, is paid for by the proper investment, the premium, of our spare hours.

Regardless of what our individual expectancy is in the way of the number of years to be lived, it is up to each of us to improve the quality of those years, to determine what we shall get out of them for ourselves and what we shall be able to do for others during our time on this earth.

In looking through my scrapbooks the other day, I came upon the following editorial by that distinguished writer, Angelo Patri, on this very subject, "The Spare Hour." It expresses some of my thoughts on the subject better than I can get them across in my own words:

Seize and Use the Golden Minutes

"Life holds nothing else so precious as time; yet how we waste its in-between hours! Unless we can see a long stretch of free time ahead, we decide we have none and sit down to sigh. If only we had time!

"Meanwhile the fruitful hours dribble through our childishly inert and feeble fingers, drift off into eternity, bearing with them the very essence of life. Dimly sensing our loss, we protest our misfortune, crying aloud by the wayside to all who, idle as ourselves, have the time to listen.

"The wiser man snatches at each fragment of time that touches his waiting spirit and packs it full of the inner cores of life: a bit of labor that will further some cherished end, a scrap of melody stored for a day of need, an act of friendliness to tie a bond of love, perhaps a time of searching meditation. Time will ripen all for the day of the harvest.

"When the flood swept the beautiful valley of Vermont, it laid a heap of tortured earth and stone upon a farmer's garden spot. 'Now, how are you ever going to lift that heap of stone?' asked a doleful neighbor.

" 'Well, I don't calculate to lift it all at once. I'm going to build me a retaining wall out of it in my spare time.' Wise man!

"Time in which to do the things we desire to do rarely comes to us in long, smooth stretches, day following day and year merging into year of rhythmic progress and harmonious accomplish-

ment. Life fills time in odd patches, seemingly regardless of the ticking of the clock. Children are born, flowers bloom, people live and die at any hour, any minute of the twenty-four, at any time of the year that meets the event. We are scarcely aware of the process until the pattern is complete.

"Each hour offers gifts of opportunity to those wise enough to grasp and use them. The man who reads his favorite books for fifteen minutes daily because he cannot read for an hour, the woman who gathers bits of furniture wherever she can find them for the home she hopes to build some day, the farmer who uses the odd minutes to lay up a retaining wall, are far wiser than those who stand by hiding smiles behind their hands. He who, though unable to see down the long slant of the years to his goal, makes use of each vagrant minute, is a prophet and a seer whose vision shall come true.

"The calendar of the new year lies in your hand, a chunky little pad, tightly sealed about the edges, one sheet only showing, truly symbolic of the year to come. You may not know what it brings to you until the time writes across the scroll, but in each day there is one shining instant dedicated to your deep desire. Seize it. Use it. Only so can you hope to bind time to your purpose and round out your day in the perfect proportion which is beauty—no broken thread, no loose ends, no aimless gestures to mar its close. Only so can you know the quiet peace of timely evening that sends you to your 'resting bed, weary and content and undishonored.' "

"I Am the Master of My Fate"

This editorial was written at New Year's time. But we can't afford to devote only New Year's day to good resolutions and the laying of plans, the taking of personal inventories of hours and dollars. That's a job for any day in the year. Today is a better day for a personal stock taking, a check of our perspective of and distance from chosen objectives, than tomorrow or the far off "some day."

If we wait for the Utopian "some day" when we have no worries and plenty of hours and dollars to do the things we want to do—should do—we shall probably never get around to doing many of them. The thing to do is to stop pining and wishing for miracles, looking for the easy Royal Road or the simple hypodermic injection that will make all our dreams come true overnight.

One result of my study of the careers of literally thousands of men and women, in all walks of life, has been the firm conviction that the truly determined person can within reasonable limitations control his own circumstances and avoid being shoved about like an inanimate pawn on life's chessboard.

Whether or not we have time to do a thing usually depends on how genuinely we actually want to do it. If it's just a pleasant hazy idle wish, we won't do it. If, for instance, we take a trip to New York and "don't have time" to look up poor old Cousin Jennie whom we haven't seen for years, it usually means that we prefer to look up the fish in the Battery Aquarium, the monkeys in the Bronx Zoo, the Chrysler Tower, Grant's Tomb, the Fifth Avenue shop windows, the night clubs or the latest Broadway hit, things that seem more important or more interesting at the time. Quite likely we neglect Cousin Jennie. Poor old soul, we wanted to see her terribly, but just didn't have the time to get around to it.

We Do What We Want to Do Most

So with our everyday life, our everyday budgeting of hours, dollars and nerve force. It's a matter of relative values, of the importance of various activities, as each of us sees them, which determines the activities that actually get crowded into our time budgets. Aside from the necessary work of the day we get done just about what we want to do hard enough, with the genuine desire that each individual must supply for himself.

Now, it is difficult to be specific in prescribing definite time budgets to private duty nurses. I know enough of their work to know that their cases sometimes take practically all of their waking hours and every ounce of energy and stamina that they have. Their situation is different from that of the business woman who has definite hours of, say, nine to five at the office or store and who can budget her time every day so that, allowing for several hours each evening with family or friends and the necessary seven or eight hours of sleep, she can still salvage an hour or two each day for self-improvement.

Nevertheless, in between cases and while working on certain types of cases, most private duty nurses have plenty of time for constructive self-improvement if they genuinely want to use their spare time in this way. With the irregular demands that are made on their time, it will require more frequent altering of plans than in the case of the business woman. It will require more self-discipline, but fortunately they have more than the average amount of determination or they could not be successful in the difficult craft of nursing.

Certainly they will be helped toward their goal and will get more done if they have a definite program, no matter how frequently it has to be altered. For all of us are mentally lazy and easily

fall prey to that human tendency to procrastinate, to wait for the ideal "some day" which seldom comes. This is the answer—plan your work and work your plan, in spite of obstacles, in spite of discouragements, in spite of sidetracks that seem for the time to lead you away from the main line to your objectives.

William James, the great psychologist, said that the average man becomes an old fogy at the age of twenty-five. There are many exceptions to this, however. I know persons of seventy or eighty who are younger mentally in their outlook on life, in their grasp of affairs, in their eager enjoyment of the fascinating panorama of human comedy and tragedy than the average person of twenty-five. Why? Simply because these youngsters of seventy and eighty refused to be pigeon-holed, to be put on the shelf and would not let themselves go stale, because they kept their mental spark plugs alive with the electricity of ideas, because they budgeted their spare hours and were wise in their use of them.

All of us can, if we will, make ourselves more interesting and valuable to our friends, family, clients and community by continually widening our cultural backgrounds and adding to our range of practical information—if we will but to do so. And the effort is tremendously worth while, in the living of a truly well rounded life.

You Can Teach an Old Dog New Tricks

Not so many years ago the high school or nurse's certificate, or college degree, was looked upon by its possessor much as a butcher looks upon the indelible Government stamp on a ham, meaning that so much meat had been inspected, certified and passed—a perfect, finished product. Many people actually believed that the capacity to learn, to grow mentally, vanished with the teens or the twenties.

Not so today. We know from psychologic research and intelligence testing that the capacity to learn actually increases with the years, provided of course that we don't let our mental muscles atrophy.

There are actually one and a half million adult students of home study courses in this country today, more than twice as many as are enrolled in all of the resident colleges and professional schools in the United States put together.

It is an interesting fact that at Columbia University, the country's largest school, with 40,000 resident students, more than one-fourth of the 50,000 home students are over forty years of age and more than half of them are over thirty. People have come to realize that education is a life-long process, not a thing for youth alone. That, it seems to me, is a very heartening and encouraging development.

Our president, Dr. Nicholas Murray Butler, who is a leader in the adult education movement in this country, made a statement in a speech delivered recently in New York City that impressed me greatly. He said that if one's intellectual and spiritual velocity is rising at the age of forty, it is quite apt to go on rising as long as one lives.

Now there is one splendid objective—to be within that charmed circle of fortunate persons who never grow old, in the sense that they remain curious, eager and alert, who continue to grow and serve on a larger scale, until this race against time called "life" is run, and our performance entered finally on the Almighty's score-book.[1]

A Visual Staff Review for a Maternity Unit

By Robert L. Dickinson, M.D., F.A.C.S.
New York City

If a systematic publication of results is the best stimulus to good work and the surest brake on careless or ill-judged surgery, then any device which keeps such results in mind is to be commended.

In the staff room of the obstetric department of Harper Hospital, Detroit, a large blackboard carries a full summary of the work of the previous month. Thus, at a glance, the visitor observes the amount and the character of the work done. He can readily make certain inferences. The incidence of certain procedures is a partial gauge of surgical judgment. Mortality, morbidity and casualties measure the conscientiousness and expertness of the service rendered. Relevant data are entered opposite casualties, as with stillbirth, "maceration," "autopsy," and the findings, in order to "clear" or not to clear the obstetrician of responsibility for failure, as when calamity is inevitable. One may hope that in annual summaries the various services will be compared in parallel columns, and, if the numbers are sufficiently large, even by recording the work of individuals.

This last word in visualizing results is in keeping with the plan and finish of this new maternity unit, which shows a thoughtfulness for the comfort of the patient (and the doctor) and a taste not always combined with this high point of technical equipment.

[1]Read at a meeting of the Iowa State Association of Registered Nurses, Des Moines, Iowa.

NEWS OF THE MONTH

Pennsylvanians Hear Speeches on Economic Subjects

THE eleventh annual convention of the Hospital Association of Pennsylvania was held in Pittsburgh on March 15, 16 and 17, with M. H. Eichenlaub, superintendent, Western Pennsylvania Hospital, Pittsburgh, presiding. Addresses of welcome and response were given at the first session, and on Wednesday morning the second session opened with Vice-President Henry G. Yearick, superintendent, Homeopathic Hospital, Pittsburgh, presiding.

After many of the reports were given, President Eichenlaub presented the annual address, and this was followed by an interesting paper entitled "Hospital Management as a Business Undertaking" which was read by Lewis N. Clark, managing director, Germantown Hospital and Dispensary, Philadelphia. It appears on page 59 of this issue.

In the afternoon Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, conducted a most interesting round table on "Medical, Nursing, Administrative and Economic Problems." Doctor MacEachern also took occasion at this time to present many of the notables present.

The evening banquet was presided over by President Eichenlaub as toastmaster, and the principal speaker was Dr. Arthur Walwyn Evans, Rochester, N. Y. His topic was "The Mirth of Nations," and his talk proved enjoyable.

On Thursday morning Mr. Eichenlaub presided, and the first address was given by Paul H. Fesler, president, American Hospital Association, and superintendent Wesley Hospital, Chicago, in which he fully explained the movement to hospitalize veterans in civilian hospitals, and he urged the cooperation of the Pennsylvania Association in the movement. Dr. David R. Craig, research bureau for retail training, University of Pittsburgh, spoke on "Research and Training in Hospital Administration," and Mrs. I. Albert Liveright, secretary, Department of Welfare of Pennsylvania, presented the last paper on "The Relation of State Aided Hospitals to the Department of Welfare."

At noon an enjoyable luncheon of the Catholic Sisters attending the meeting was held, and at this time Doctor MacEachern was the speaker.

At the last session, Dr. Q. A. W. Rohrbach, school of education, University of Pittsburgh, gave an interesting dissertation on the "Technique for the Selection of Personnel for Professional Training." Doctor Rohrbach has made a study of the requirements for nurse education, and explained to those present methods by which they could obtain the best types of student nurses. The last paper on the program was given by John A. McNamara, executive editor, THE MODERN HOSPITAL. Mr. McNamara had made a full economic survey of conditions of hospitals in Pennsylvania, and presented his findings.

The meeting closed with the installation of the new officers. John M. Smith, director, Hahnemann Medical College and Hospital, Philadelphia, became the president, succeeding Mr. Eichenlaub and Jessie J. Turnbull, superintendent, Elizabeth Steel Magee Hospital, Pittsburgh, was chosen president-elect.

New York Chosen for A. D. A. Meeting in November

The fifteenth annual meeting of the American Dietetic Association will be held at the Hotel Pennsylvania, New York City, November 7 to 11.

Emma Feeney, Pratt Institute, Brooklyn, N. Y., is in charge of the program.

Canada Public Health Association to Meet May 25-27

The Canadian Public Health Association will hold its twenty-first annual meeting in Toronto, May 25 to 27, in conjunction with the sixteenth annual meeting of the Ontario Health Officers Association.

NEWS OF THE MONTH (Cont'd)

Many Practical Projects Discussed by Ohio Association

ALMOST practical program occupied the sessions attended by the members of the Ohio Hospital Association at their eighteenth annual convention in Akron, March 15 and 16. The attendance this year was as great as in previous years, and the many worth while projects that are being fostered in that state were discussed by the various members of the association.

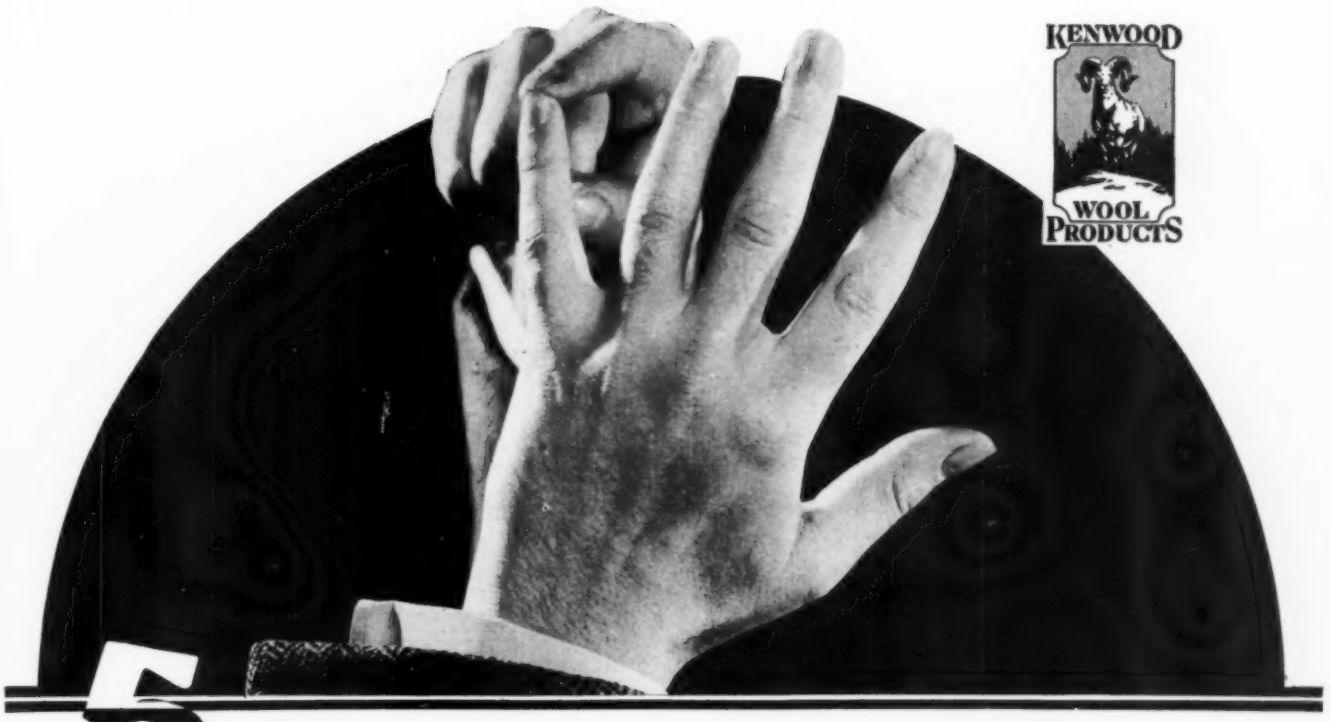
Mary A. Jamieson, superintendent, Grant Hospital, Columbus, presided at the first session, which followed a pleasant luncheon, and B. W. Stewart, superintendent, Youngstown Hospital, Youngstown, was the first speaker. He presented the new admitting procedure that has been worked out in Cleveland and other cities of the state. Guy J. Clark, executive secretary, Cleveland Hospital Council, was present to answer any and all questions regarding points that were brought up.

The second paper was presented by Harry Graef, superintendent, Children's Hospital, Akron, on the subject of hospital contracts (with employees and vendors). Another paper which proved to be of more than usual interest was presented by Paul L. Bliss, Cleveland, on the subject of industrial insurance problems. Mr. Bliss outlined ways and means of reducing premiums through additional care and precaution against hospital accidents, and told of the many unusual accidents that were reported to the industrial insurance commission. The session closed with a paper by Worth L. Howard, Welfare Federation, Cleveland, on uniform accounting.

The annual banquet was held in the evening, at which time there were no formal speakers. Speeches, however, were heard from many of those present, including Paul H. Fesler, president, American Hospital Association, and superintendent, Wesley Hospital, Chicago.

On Wednesday, Ira J. Dodge, newly appointed superintendent, Huron Road Hospital, Cleveland, acted as chairman. Frank W. Hoover, superintendent, Elyria Memorial Hospital, Elyria, told of the possible elimination of some of the printed forms in hospitals, and an excellent round table was conducted by Arden E. Hardgrove, superintendenty, City Hospital of Akron. Other speakers were F. E. Baxter, and Dr. John H. J. Upham, dean, Ohio State University College of Medicine.

B. W. Stewart, Youngstown Hospital, Youngstown, was chosen president-elect of the association.



5 Blanket Facts to Which Kenwood Alone Can Point

Now with *Value* playing so vital a part in the purchase of hospital equipment you are entitled to know these facts about Kenwoods

ONE Kenwood Blankets are all wool of selected long fibre, woven and finished expressly for hospital service. Not merely a sound wool blanket, but one which from fibre to finished product is constructed to fulfill the special requirements of the modern hospital.

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NEWS OF THE MONTH (Cont'd)

Iowa Hospital Meeting Attracts Splendid Delegation

AN UNUSUALLY successful meeting of the Iowa Hospital Association was held in Sioux City, March 9 and 10. There was a registration of 152, and fifty cities and towns of Iowa were represented in the total count.

The first session was presided over by President Robert E. Neff, administrator of the University Hospitals, Iowa City, and after greetings delivered by the Rev. G. T. Notson, superintendent, Methodist Hospital, Sioux City, F. P. G. Lattner, superintendent, Finley Hospital, Dubuque, read a paper describing "Ten Years' Operation of the Pathological and X-ray Laboratory Service Under Full-Time Direction." This paper was discussed by Clinton F. Smith, superintendent, Allen Memorial Hospital, Waterloo. R. A. Nettleton, superintendent, Methodist Hospital, Des Moines, gave his report on hospital charges based upon questionnaires sent out to all the hospitals in the state. There was distributed at this time a copy of his findings. Dr. Kate Daum, chief dietitian, University Hospitals, Iowa City, gave an excellent talk on present day food costs, showing what could be done to improve feeding of patients without increasing the dietary budget. The morning session ended with a paper on hospital legislation which was presented by T. P. Sharpnack, executive secretary, Broadlawns Hospital, Des Moines.

The afternoon session was presided over by John A. McNamara, executive editor, THE MODERN HOSPITAL, Chicago, and was devoted to trustee problems. After two papers were read, one by the Rev. C. H. Kamphoeffner, secretary, board of trustees, Methodist Hospital, Sioux City, and the other one written by Morris Sanford, president, board of trustees, St. Luke's Hospital, Cedar Rapids, and read by the Rev. J. P. VanHorn, superintendent, St. Luke's Hospital, Cedar Rapids, a round table discussion followed.

In the evening the annual banquet was held, and at this time Paul Fesler, president, American Hospital Association, talked upon the feasibility of hospitalizing veterans in civilian hospitals, and urged the cooperation of the Iowa Association. An exceptionally fine address was then delivered by Dr. W. L. Bierring, Des Moines, on "The Hospital as a Community Asset," and the evening closed with a colorful and instructive pageant on the history of nursing.

Thursday morning sessions were given over to four papers, the first by E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, on the economic aspects of nursing, which was discussed by Margaret Stoddard, superintendent, City Hospital, Newton; the second by E. C. Pohlman, assistant to the administrator, University Hospitals, Iowa City, on financial and statistical reports; the third on the hospital staff library by Dr. Allan C. Starry, director, department of clinical pathology, St. Joseph's Mercy Hospital, Sioux City, and the last by Helen Beckley, executive secretary, American Association of Hospital Social Workers, on "Social Problems in the Small Hospital."

Film Pictures Arouse Interest

At the luncheon meeting talking pictures were shown describing the features in hospital administration.

The last session was given over to a round table which was conducted by Dr. Malcolm T. MacEachern, director of hospital activities, American College of Surgeons, Chicago, and Mr. McNamara. The questions were all of an economic nature and much discussion ensued.

The results of the election were as follows: president, Clinton F. Smith; first vice-president, George L. Rowe, manager, Polyclinic Hospital, Des Moines; second vice-president, Margaret Stoddard; secretary, E. C. Pohlman; treasurer, R. A. Nettleton. Two trustees were reelected, Sister Benedicta, superintendent, Mercy Hospital, Des Moines, and Emma Lucas Louie, superintendent, Jennie Edmundson Memorial Hospital, Council Bluffs.

Some of the sessions of the Iowa Hospital Association were attended by members of the Iowa State Dietetic Association, which also met at this time. Separate meetings, however, were held by

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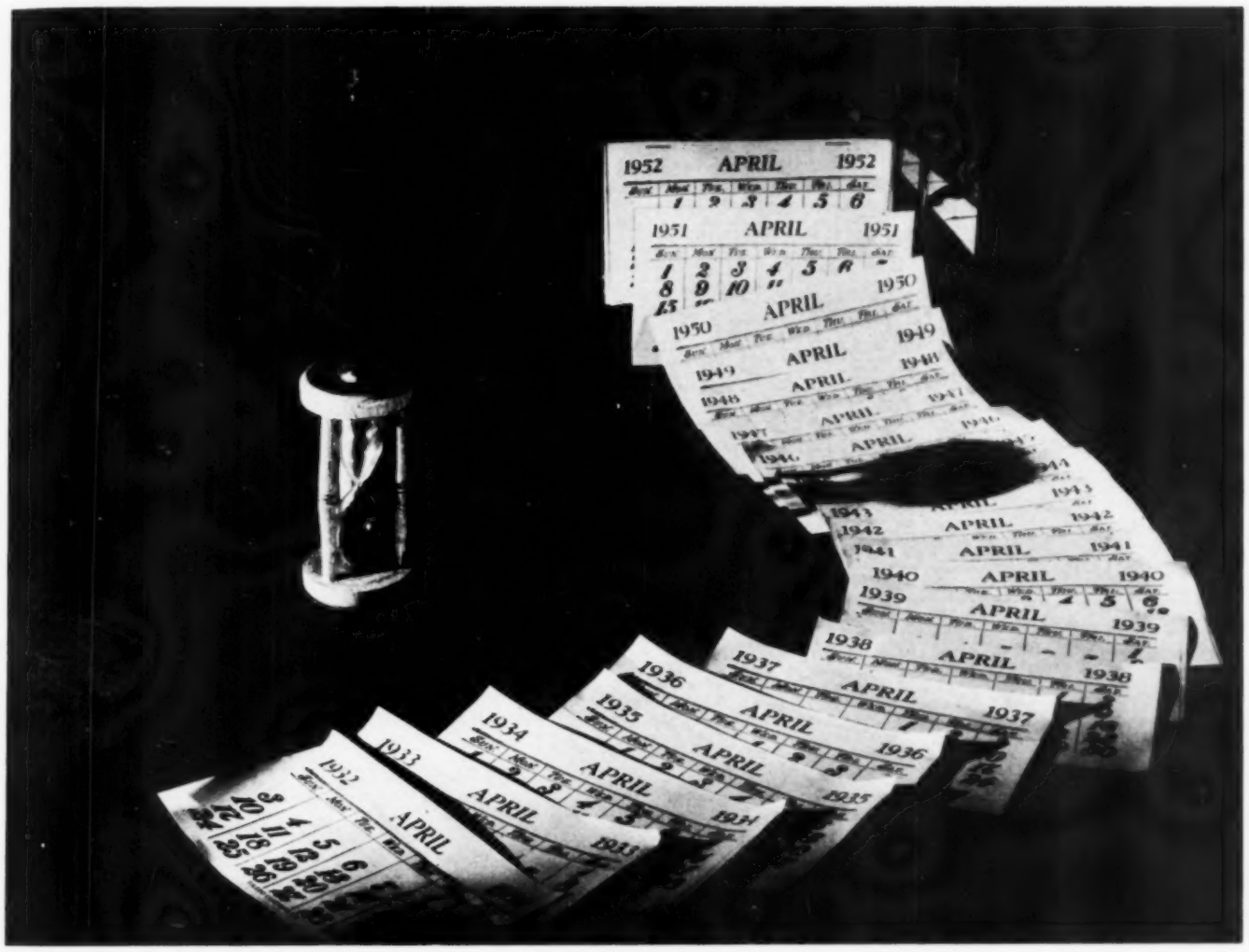

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NEWS OF THE MONTH (Cont'd)

the dietitians in the afternoon of Wednesday, and the morning of Thursday. Dr. Kate Daum presided at these meetings, and the speakers were as follows: Lois B. Corder, school of nursing, University of Iowa, "New Aspects of Nursing Education"; Wanda Bahl, Broadlawns, Des Moines, "Methods of Interesting the Student Nurse"; Clinton F. Smith, "Responsibilities and Duties of the Dietitian in the Small Hospital"; Dr. F. H. McBride, Sioux City, "Factors Other Than Diet Causing Malnutrition in Children"; Dr. W. D. Paul, department of theory and practice of medicine, University of Iowa Medical School, "Experiments in the Treatment of Peptic Ulcer"; Dr. W. F. Petty, director, city and county health unit, Sioux City, "Health Activities in Woodbury County."

While these two meetings were in progress the record librarians of Iowa, under the direction of Doctor MacEachern were forming a state association. There were eleven librarians present, and they chose Edna Hoffman, St. Luke's Hospital, Davenport, as president, and Elizabeth Parker, Broadlawns, Des Moines, as secretary.

Moderate Rate Unit Is Opened at Sydenham Hospital

The moderate rate unit of Sydenham Hospital, New York City, opened on March 10.

This unit is described in the hospital's announcement to be "for the benefit of the white collar class. Adequate hospitalization and medical service will be given at a moderate cost."

Physicians who use the unit are held to a definite fee schedule. These fees are listed as follows: for difficult major operations, $100 to $150; for ordinary major operations, $75 to $100; for minor operations, $10 to $50; medical fees for the first week, $25; for the second week, $20; for the third week and over, $15 each week, up to a maximum total of $150; interconsultation fees, $5.

Group nursing with suitable arrangements of the rooms has been decided upon as a means of satisfying the patients and physicians, this group nursing to be dispensed with as soon as patients are convalescing or are well enough to be satisfied with floor care.

All hospital and laboratory service is to be given at cost.

Auto Accident Cases Discussed by A. H. A. Committee

That the application of the principles of workmen's compensation to automobile accident policies, thereby eliminating the factor of negligence which now makes accident policies inoperative in many cases, would be of great value to all hospitals in increasing their ability to obtain reimbursement for treatment given to emergency cases, was discussed at length by the American Hospital Association's committee on workmen's compensation and liability that met at the Orange Memorial Hospital, Orange, N. J., February 9.

This thesis is set forth in a report by the committee to study compensation for automobile accidents, sponsored by the Columbia University Council for Research in the Social Sciences. The report deals with the economic and social aspects of automobile accident cases, and should be read by all hospital administrators, the A. H. A. committee pointed out. Copies which are nominally priced at $1 a copy, may be obtained from Shippen Lewis, Commercial Trust Building, Philadelphia.

The committee also voted to approve the preparation of a simple manual for the guidance of hospital authorities in handling accident cases.

The committee approved in principle the action of the Beekman Street Hospital, New York City, by which that hospital has served notice upon insurance companies that compensation cases will be billed at the hospital's charges of approximately $6 a day. The committee recommends that all hospitals adopt this policy whenever possible as a means of obtaining more nearly adequate reimbursement for the services they are compelled to give to the victims of accidents.

The chairman of the committee, F. Stanley Howe, superintendent, Orange Memorial Hospital, reviewed the activities of the past year, with special reference to the contact established with the National Bureau of Casualty and Surety Underwriters.

Paul H. Fesler, superintendent, Wesley Memorial Hospital, Chicago, and president, American Hospital Association, was present at the meeting. Other members who attended were Melvin L. Sutley, superintendent, Delaware County Hospital, Drexel Hill, Pa., and Milton W. Gatch, superintendent, Maryland General Hospital, Baltimore.

NEWS OF THE MONTH (Cont'd)

Illinois, Indiana, Wisconsin Prepare for Best Meeting

WHAT promises to be by far the most interesting meeting yet to be held by the Illinois, Indiana and Wisconsin hospital associations is that which will take place in Chicago, April 27, 28 and 29. According to present indications the registration will exceed that of previous years, and the program has been so well and so carefully planned that every hospital executive and worker who attends will be given much practical help in solving his or her individual problems.

Registration will be held early on Wednesday morning, April 27. This will be followed by visits to the exhibits in the exposition hall of the Hotel Sherman. Later the individual associations will hold special meetings, Indiana meeting alone for a specially prepared program and Illinois and Wisconsin joining for a round table conference, which will be led by Dr. R. C. Buerki, superintendent, State of Wisconsin General Hospital, Madison. At noon, the Indianians will hold a Hoosier luncheon to which the Illinois and Wisconsin groups have been invited. The Indiana association will meet again in the afternoon, and Illinois and Wisconsin will again join in a round table conference, this time on departmental management.

A joint meeting of the three associations will be held on Thursday morning at which time a report of economic surveys of the hospital situation in the three states will be presented. The question has been stated in the program as follows: How are hospitals adjusting their policies to meet present economic conditions in relation to (1) procedure in admitting patients; (2) rates and extra charges; (3) collections; (4) types of accommodations; (5) salaries; (6) number of personnel; (7) nursing service; (8) student nurse allowances; (9) use of drugs and dressings; (10) departmental economies—x-ray, clinical laboratory, physical therapy, food service, laundry, light, heat and power; (11) increasing utilization of hospital facilities; (12) increasing revenue? Following this conference, the presidents of the three associations will each give an address.

A round table conference on business administration will be held in the afternoon. Topics for discussion will include: principles involved in the organizing and functioning of the business department of the hospital; scope of the business department in a hospital; location, layout, equipment including mechanical aids; personnel, type, qualifications; simplifying bookkeeping and accounting; charges, regular and special; determination of unit costs; meeting deficits; auditing accounts; monthly and annual financial reports.

Mr. Wordell Will Preside at Banquet

The Tri-State Hospital Association banquet will be held in the evening, with Charles A. Wordell, director, St. Luke's Hospital, Chicago, as toastmaster. The address of the evening, "What the American Hospital Association Is Doing for You," will be given by Paul Fesler, president, American Hospital Association.

The Friday morning program will consist of speeches on a variety of subjects. The speeches, which are to be limited to twenty minutes each, will discuss such topics as: the control of noise within and without the hospital; a plan of publicity and community relations for hospitals; promoting morale, harmony and good will throughout the institution; keeping abreast with the advances in hospital administration; should general hospitals extend their services to mental and tuberculous patients?

The closing session, which will consist of demonstrations and a round table conference, will be under the guidance of Dr. M. T. MacEachern, associate director, American College of Surgeons.

Other speakers who will take a leading part in the program are: Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago; Mabel Binner, superintendent, Children's Memorial Hospital, Chicago; J. Dewey Lutes, superintendent, Ravenswood Hospital, Chicago; Albert G. Hahn, business manager, Protestant Deaconess Hospital, Evansville, Ind.; John A. McNamara, executive editor, THE MODERN HOSPITAL.

NEWS OF THE MONTH (Cont'd)

Interesting Program Announced for Southern Meeting

THE hospital associations of Arkansas, Kentucky and Tennessee will meet in joint session in Memphis, Tenn., April 18 and 19.

Each state association will hold a separate meeting on the morning of the first day. The joint sessions will begin in the afternoon, with Dr. Eugene Elder, president, Tennessee Hospital Association, and superintendent, Knoxville General Hospital, Knoxville, Tenn., presiding. The invocation will be given by the Rev. Thomas K. Young, Idlewild Presbyterian Church, Memphis, and the delegates will be welcomed by the Hon. Watkins Overton, mayor of Memphis.

The first formal paper will be presented by Miss Fairfax Proudfit, University of Tennessee College of Medicine, Memphis, and chairman, dietetic section, American Hospital Association. Her subject will be "Some Dietary Problems With Special Reference to Hospitals of the South." Matthew O. Foley, editorial director, *Hospital Management*, will speak on "Are Hospital Superintendents Luxuries or Necessities?" Miss Lake Johnson, superintendent, Good Samaritan Hospital, Lexington, Ky., will discuss the question, "Are Flat Rates and Deferred Payments Proving Practical?" The final paper at the first afternoon session will be given by Dr. B. A. Wilkes, past president, American Protestant Hospital Association, on "The Burden of Auto Accidents on the Small Hospital."

Delegates will be taken to visit various Memphis hospitals later in the afternoon, following which an entertainment will be presented by the Memphis Hospital Association and the Tennessee League of Nursing Education.

Hospital Rates Theme of Morning Session

Lee C. Gammill, president, Arkansas Hospital Association, and superintendent, Baptist State Hospital, Little Rock, Ark., will preside at the morning session of the second day's program. Those who will appear on the program, together with the subjects of their papers, are: Emma H. Krazeise, director, Children's Bureau, Louisville, Ky., "Workmen's Compensation"; W. Hamilton Crawford, superintendent, South Mississippi Infirmary, Hattiesburg, Miss., "Should Hospital Rates Be Reduced?" and Mgr. John P. Fisher, director, Catholic Hospitals in Arkansas, "How Surgeons and Physicians Can Help Us Lower the Cost of Hospital Care."

Papers will also be presented by Dr. Bert W. Caldwell, executive secretary, American Hospital Association, and Jane Van De Vrede, Atlanta, Ga., first vice-president, American Nurses' Association. Dr. E. T. Thompson, administrator, Indiana University School of Medicine and Hospitals, and president, Indiana Hospital Association, will bring the joint session greetings from the hospital executives in the state of Indiana.

A. H. A. President to Speak

Agnes O'Roke, president, Kentucky Hospital Association, and superintendent, Kosair Crippled Children Hospital, Louisville, Ky., will preside at the afternoon session. The first paper will deal with the work of the Committee on the Grading of Schools of Nursing and will be presented by Alma Scott, assistant director, American Nurses' Association. Mrs. Scott's paper will be discussed by Eva Atwood, Fort Smith, Ark., Flora Keen, Louisville, Ky., and Hazel Goff, Knoxville, Tenn. "Trends in Sickness Insurance in the United States," will be discussed by C. Rufus Rorem, Julius Rosenwald Fund, Chicago. The last speaker at this session will be Paul H. Fesler, president, American Hospital Association, and superintendent, Wesley Memorial Hospital, Chicago, whose subject will be "What the American Hospital Association Does for You."

A round table discussion conducted by John A. McNamara, executive editor, THE MODERN HOSPITAL, will bring the second day's afternoon session to a close.

The two-day program will end with a banquet and the organization of a Southern Hospital Association. The address of the evening will be made by Dr. Casa Collier on "African Hospitals and Big Game."

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NEWS OF THE MONTH (Cont'd)

Large Kansas Hospital Is Given to Charity

Because of an attempt by the Federal Government to levy taxes on fees that have been earned but never collected, the Halstead Hospital, Halstead, Kan., has been turned over to the Sisters of St. Joseph by the owner, Dr. Arthur E. Hertzler. Doctor Hertzler said the move was made necessary by the strange workings of the income tax law, which levied on the earnings of the hospital on an accrual basis, making it impossible to operate further the hospital under private ownership.

The hospital, a 220-bed institution, has been legally transferred to the Sisters. The Agnes H. Hertzler Memorial Clinic will continue under Doctor Hertzler's control, and both the clinic and the hospital will operate as they have in the past.

Switzerland Forms Hospital Association

A hospital association has been formed in Switzerland, under the title "Veska," says a recent announcement.

The first publication to be issued by the new association is a 800-page volume, with nearly a hundred pages devoted to advertisements. The articles cover a variety of subjects such as kitchen equipment, telephones, foodstuffs, floorings.

Among the objects of the association are the establishment of a central bureau to study hospital affairs and the unification of statistical information.

Record Librarians to Meet This Year With A. H. A.

The Association of Record Librarians of North America will meet this year with the American Hospital Association in Detroit. The dates of the meeting have been announced for September 12 to 16.

Northeastern New York Group Meets in Albany

The Hospital Association of Northeastern New York, which was formed in June of last year, met for a one-day conference in Albany, March 22.

Three sectional meetings were held. The administrative section presented its program in the morning, the medical section in the afternoon and the trustee section in the evening.

Dr. H. H. Dier, Albany Hospital, is the secretary-treasurer of the recently formed association.

Towering above the Hudson in upper Manhattan, the Columbia-Presbyterian Medical Center offers the finest service in healing, teaching and research. The tall building at the left is Bard Hall dormitory; next is the Psychiatric Institute, and slightly back of it the Neurological Institute. Maxwell Hall, the nurses' residence, is in the center, and the Presbyterian Hospital and Harkness Pavilion occupy the large building at the right, with the Medical and Dental Colleges back of it to the left and the Babies' Hospital to the right.

NEWS OF THE MONTH (Cont'd)

New York's Lawmakers Asked to Study Hospital Problems

That the New York legislature give "immediate study and consideration" to medical and hospital problems connected with workmen's compensation insurance, is recommended by Governor Franklin D. Roosevelt in transmitting the preliminary report of the committee appointed by him to review such problems. Howard S. Cullman, president, Beekman Street Hospital, is chairman of the governor's committee.

The subcommittee on hospital problems, which was headed by Dr. S. S. Goldwater, hospital consultant, New York City, recommends: (1) that hospitals be adequately paid for services rendered in compensation cases and that an amendment to the law be made that will entitle charitable or municipal hospitals to charge the reasonable cost of services rendered without regard to "ward" or other rates established by them; (2) that authorization by the employer for payment of hospital charges should not be required; (3) that a lien law similar to that in New Jersey be enacted, giving the hospital liens on judgments awarded to patients in damage suits; (4) that hospitals be advised within a definite time whether cases are to be contested.

Governor Roosevelt singled out for special mention that part of the report of the subcommittee on medical problems that recommended that "the scope of the workmen's compensation law be enlarged to cover all occupational diseases." Dr. Adrian S. Lambert is chairman of the subcommittee on medical problems.

This group also went on record as disapproving the practice of "lifting"—defined as the practice on the part of insurance agents of inducing compensation claimants to change medical attendants by means of threats or offers of a pecuniary nature. It also expressed the opinion that the maintenance of clinics by insurance companies is unsatisfactory and suggested that a series of clinics be created under the supervision and direction of the state.

The subcommittee on departmental activities, headed by Max Meyer, recommended the creation of a bureau to which a claimant might go for an impartial check-up on his treatment. It further recommended the provision of suitable examination rooms in every city and recognition of the principle that a man injured while working should not become a burden to society because his employer is not insured.

Suggested bills were presented to the governor covering (1) the elimination of authorization by employers; (2) the right of hospitals to adequate remuneration; (3) elimination of the right of carriers or employees to be represented at physical examinations of injured persons.

Bills dealing with the subject of hospital liens and the extension of the occupational disease provisions are already under consideration.

Second Edition of "The Small General Hospital" Is Issued

"The Small General Hospital," which was first published in February, 1928, as Bulletin No. 3 by the trustees of the Duke Endowment, Charlotte, N. C., has been revised and is now reissued under the date of January, 1932.

Certain changes have been made in the second edition, largely in the arrangement of material and in important additions.

Part I is devoted to "general considerations, including the correct conception of the larger purpose of a community hospital; how to estimate the size of a hospital to meet local needs; factors that influence the location of a hospital; the adaptation of hospitals to different communities."

Part II is devoted to "special considerations, including details with reference to size, location, arrangement and finish of the several divisions or essential units of small hospitals, together with all built-in equipment, including wiring and lighting fixtures, plumbing and plumbing fixtures, cases, cabinets and cupboards, mirrors, shelves, towel bars, paper towel holders, telephones and signal system, sterilizers and x-ray equipment."

Part III sets forth considerations of the importance of equipment, the cost of equipment, the selection of equipment, standard equipment and equipment check lists; also differences between equipment and supplies, standard supplies and supply check lists.

Part IV is given over to drawings that show floor plans and equipment.

Part V illustrates with pictures and plans a representative group of general hospitals that have been, or are being constructed in the Carolinas, with assistance from the Duke Endowment.

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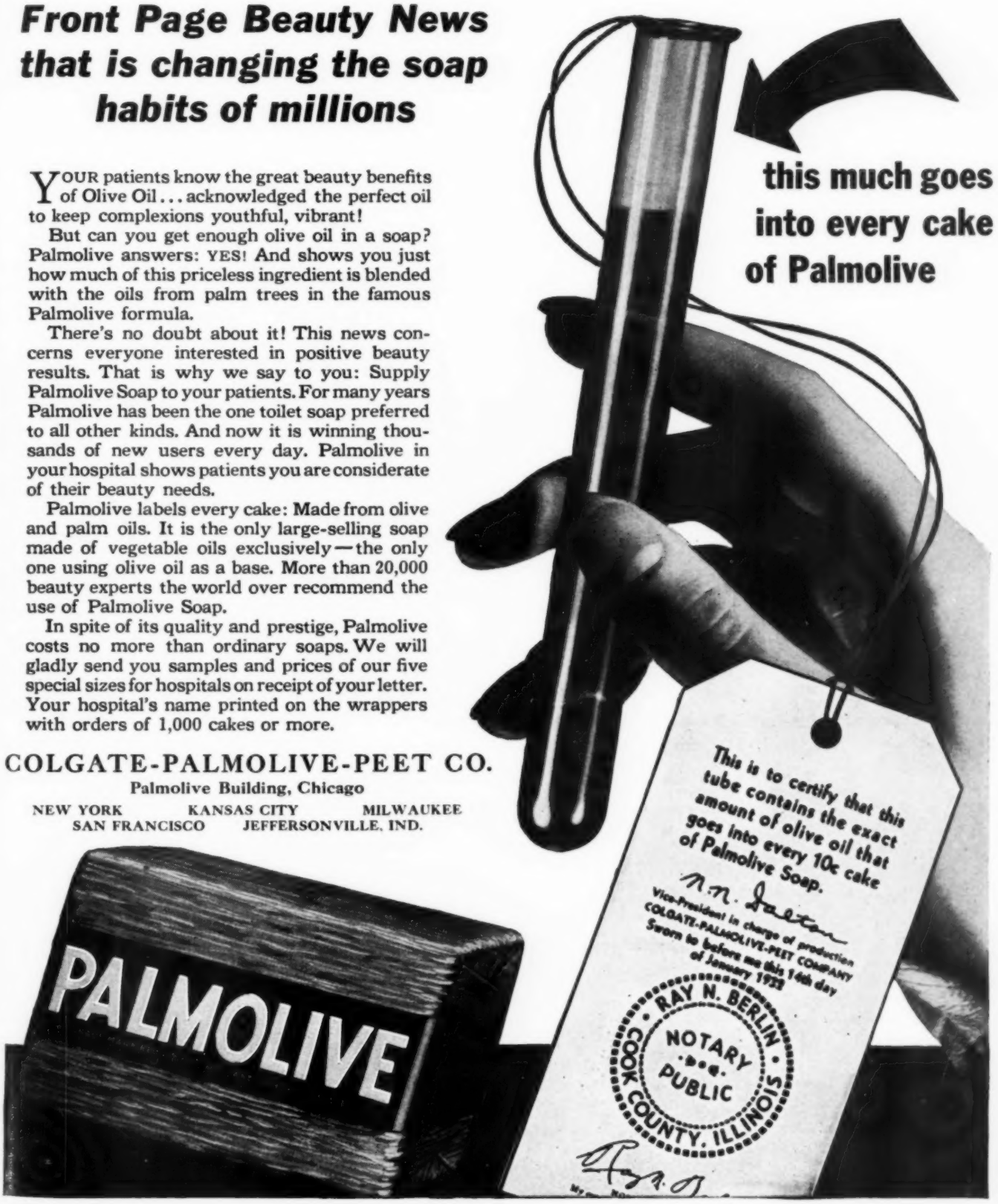

NEWS OF THE MONTH (Cont'd)

Coming Meetings

Arkansas, Kentucky and Tennessee Hospital Associations.
Next meeting, Memphis, Tenn., April 18-19.

American Association of Hospital Social Workers.
President, Elizabeth Wisner, Tulane University, New Orleans.
Executive secretary, Helen Beckley, 18 East Division Street, Chicago.
Next meeting, Philadelphia, May 14-21.

American College of Surgeons.
President, Dr. Allen B. Kanavel, 54 East Erie Street, Chicago.
Director general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, St. Louis, October 17-21.

American Hospital Association.
President, Paul H. Fesler, Wesley Memorial Hospital, Chicago.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, Detroit, September 12-16.

American Medical Association.
President, Dr. Edward Starr Judd, Rochester, Minn.
Secretary, Dr. Olin West, 535 North Dearborn Street, Chicago.
Next meeting, New Orleans, May 9-13.

American Nurses' Association, National League of Nursing Education and National Organization for Public Health Nursing.
Next meeting, San Antonio, Texas, April 11-16.

American Protestant Hospital Association.
President, Rev. A. O. Fonkalsrud, Mansfield General Hospital, Mansfield, Ohio.
Executive secretary, Dr. Frank C. English, Hyde Park, Station O, Cincinnati.
Next meeting, Detroit, September 9-12.

Association of Record Librarians of North America.
President, Maurine Wilson, Ravenswood Hospital, Chicago.
Secretary, Betty Gray, Nassau Hospital, Mineola, N. Y.
Next meeting, Detroit, September 12.

Catholic Hospital Association of the United States and Canada.
President, the Rev. Alphonse M. Schwitalla, S.J., Dean, St. Louis University Medical School, St. Louis.
Secretary, M. R. Kneifl, 1402 South Grand Blvd., St. Louis.
Next meeting, Villanova, Pa., June 21-24.

Colorado Hospital Association.
President, Frank J. Walter, St. Luke's Hospital, Denver.
Executive secretary, William S. McNary, University of Colorado School of Medicine and Hospital, Boulder.
Next meeting, Boulder, June 7.

Connecticut Hospital Association.
President, Oliver H. Bartine, Bridgeport Hospital, Bridgeport.
Secretary, Maud E. Traver, General Hospital, New Britain.
Next meeting, Middletown, May 6.

Illinois, Indiana and Wisconsin Hospital Associations.
Next meeting, Chicago, April 27-29.

Louisiana Hospital Association.
President, Dr. Arthur Vidrine, Charity Hospital, New Orleans.
Secretary, Harriett Mather, Southern Baptist Hospital, New Orleans.
Next meeting, Pineville, April 8.

Michigan Hospital Association.
President, L. J. McKenney, Highland Park General Hospital, Highland Park.
Secretary, Robert G. Greve, University Hospital, Ann Arbor.
Next meeting, Flint, April 26-27.

Midwest Hospital Association.
President, E. Muriel Anscombe, Jewish Hospital, St. Louis.
Secretary, Walter J. Grolton, Missouri Pacific Hospital, St. Louis.
Next meeting, St. Louis, June 2-3.

Minnesota Hospital Association.
President, Dr. Fred G. Carter, Ancker Hospital, St. Paul.
Secretary-treasurer, James McNee, St. Luke's Hospital, Duluth.
Next meeting, St. Paul, May 23-25.

New Jersey Hospital Association.
President, Dr. George O'Hanlon, Jersey City Medical Center, Jersey City.
Executive secretary, Marie Louis, Muhlenberg Hospital, Plainfield.
Next meeting, Atlantic City, May 13-14.

Hospital Association of New York State.
President, Carl P. Wright, Syracuse General Hospital, Syracuse.
Secretary, Julian Funt, Beth Israel Hospital, New York City.
Next meeting, New York City, May 5-7.

North Carolina, South Carolina and Virginia Hospital Associations.
Next meeting, Richmond, Va., May 17-19.

Texas State Hospital Association.
President, Robert Jolly, Memorial Hospital, Houston.
Secretary, Joe F. Miller, Jefferson Davis Hospital, Houston.
Next meeting, San Antonio, April 8-9.

Western Hospital Association.
President, Dr. B. W. Black, Highland Hospital, Oakland, Calif.
Secretary, Mrs. L. M. Armstrong, Los Angeles.
Next meeting, Salt Lake City, Utah, June 14-16.

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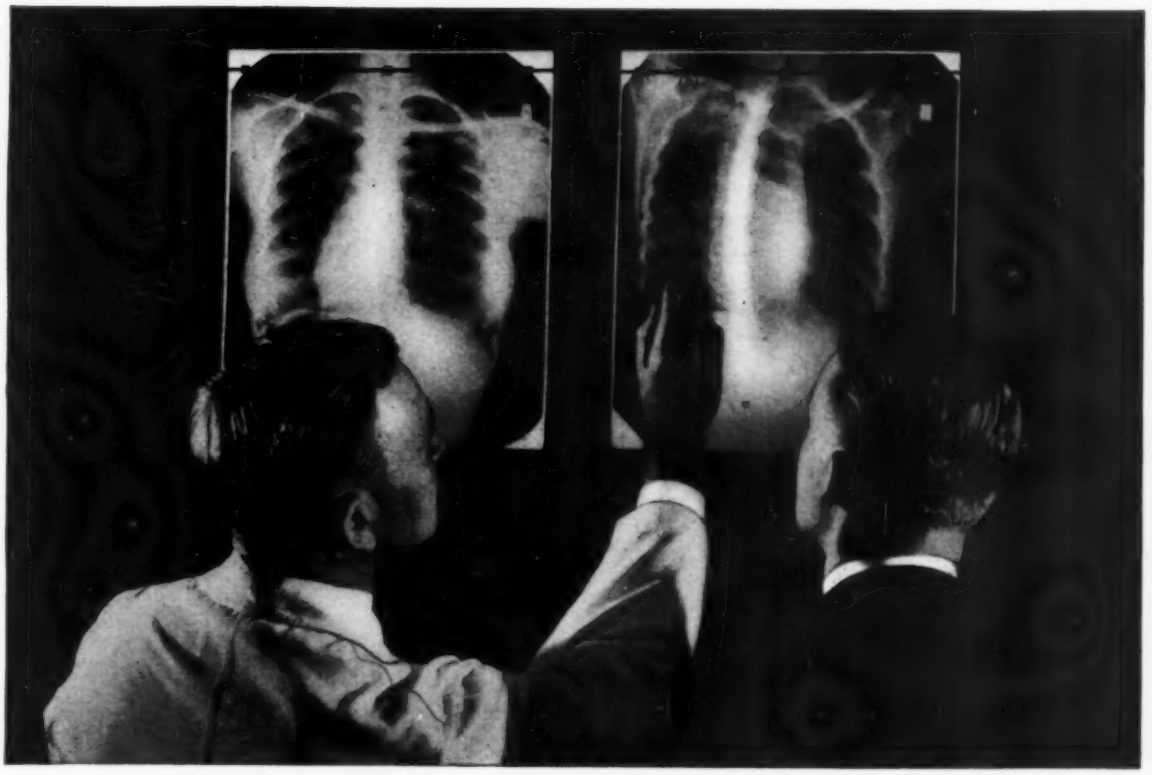

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NEWS OF THE MONTH (Cont'd)

Nurses' Biennial in San Antonio Promises Timely Program

Four major topics will concern the three national nursing organizations when they convene in biennial session at San Antonio, Tex., April 11 to 15. Between three and four thousand representatives of the American Nurses' Association, the National League of Nursing Education and the National Organization for Public Health Nursing are to join forces in considering these topics, which are of equal interest to patient, to hospital and to nurse.

"Nursing at the Crossroads" is the title under which hospital nursing costs, the findings of two five-year studies on nursing schools, and nursing service from the point of view of the public are to be considered. Dr. William Darrach, chairman, and Dr. May Ayres Burgess, director, Committee on the Grading of Nursing Schools, will speak.

"Next Steps for Nursing," a second topic for general consideration, will deal with the selection and preparation of the undergraduate nurse, of the graduate nurse and of the equitable distribution of nursing service. Katherine Densford, director, University of Minnesota School of Nursing, and Elizabeth Soule, head of the department of nursing education, University of Washington, will discuss the undergraduate and graduate training respectively.

So important in the view of the nursing organization is the mental hygiene movement as related to good care of the patient that an entire joint session ill be given over to this topic, with addresses by Dr. C. M. Hincks, National Committee for Mental Hygiene, and Effie Taylor, chairman, mental hygiene section, American Nurses' Association.

The final joint session of the three organizations will have to do with the present economic situation in nursing, which marks but a high peak in a chronic state of unemployment in nursing. Serious consideration will be given also to those developments in nursing that form the basis for the chronic oversupply in private duty and the increasing surplus of graduate nurses.

Of direct interest to the hospitals will be the round table arranged by the American Nurses' Association for hospital superintendents. E. Muriel Anscombe, superintendent, Jewish Hospital, St. Louis, will preside, and there will be papers by Anna G. Williams, superintendent, Cheyenne Memorial Hospital, Cheyenne, Wyo., and by Katherine Appel Maroney, director of nursing service, Beaumont General Hospital, Beaumont, Tex. The topics are thought-provoking: "Teamwork of the Professional Groups Within the Hospital"; "Quality of Nursing Service as Affected by Hospital Equipment"; "How Can a Small Hospital Nurse Its Patients Without a Nursing School?"

In the subject of relief and investment for nurses, the responsibility of the hospital and the nursing agency for its sick nurses will be emphasized.

At a general session of the American Nurses' Association, the topic will be "Economics and Private Duty." The subjects to be discussed at this time are of special interest. Polly Mariner Donnelly will discuss "Salary Cuts as Related to the Nonemployment of Nurses." Emma L. Collins will present the subject of "Meeting the Present Economic Problem Through Adjustment of Fees"; while perhaps the most thought-provoking topic of the program will be that of Janet M. Geister, director at headquarters, American Nurses' Association, who will speak on "Suggested Steps in Evading Another 'Depression.'"

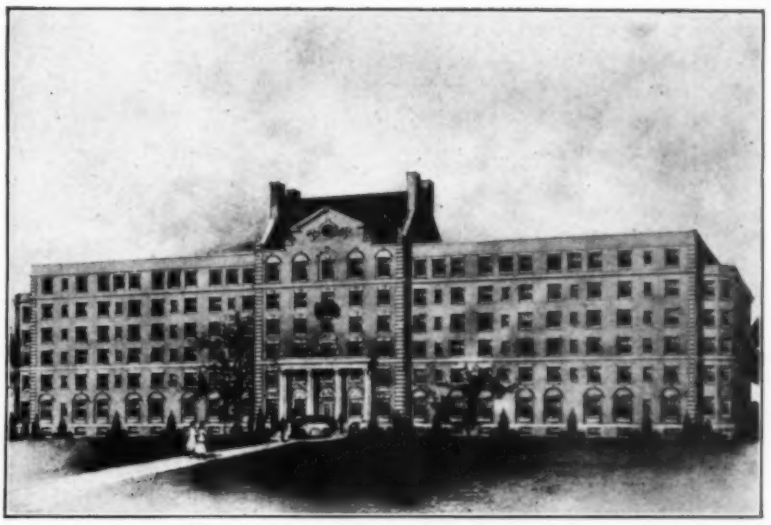
Comprising the three national nursing organizations are the American Nurses' Association, official organization of graduate nurses in the United States, with a membership of 109,000; the National League of Nursing Education, composed of educational leaders and instructors in nursing education, and the National Organization for Public Health Nursing, composed of those nurses and laity particularly interested in the development of public health nursing.

Record Librarians of Chicago and Cook County Meet

J. Dewey Lutes, superintendent, Ravenswood Hospital, Chicago, and Dr. Walter S. Priest, attending physician, Chicago Memorial Hospital, were the principal speakers at the meeting of the Association of Record Librarians of Chicago and Cook County, March 22.

Mr. Lutes' subject was "My Job," and Doctor Priest gave a discussion of the nomenclature adopted by the American Heart Association for use in diagnosing cardiac disease.

Huron Road Hospital
East Cleveland, Ohio
The Geo. S. Rider Co., Architects
Cleveland, Ohio



HOSPITALS ARE DISCOVERING

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Both sash are completely reversible and can be quickly, safely and conveniently cleaned from inside the room. Even with unskilled or staff help—this reduces the window cleaning time from 35 to 50 per cent. *Williams Reversible Windows more than pay for themselves in a few years' time.*

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PERSONALS

DR. A. J. SCANLAND, assistant superintendent, Napa State Hospital, Napa, Calif., is the newly appointed superintendent, Agnew State Hospital, Agnew, Calif. DOCTOR SCANLAND succeeds DR. LEONARD STOCKING who served as superintendent at Agnew from 1903 until his death last October.

ANNA HELEN AAL is the newly elected superintendent of Bothwell Memorial Hospital, Sedalia, Mo.

KATHRYN MCCONNELL has recently accepted the superintendency of the Greenville Hospital, Greenville, Pa.

DR. ADAM EBERLE, medical superintendent, Sea View Hospital, Staten Island, N. Y., is the newly appointed medical superintendent, Kings County Hospital, Brooklyn, N. Y., succeeding DR. CLAMOR H. MAGNA, who ended his life in January. DR. ALLEN KANE, resident physician at Sea View Hospital, has been placed in charge of that institution temporarily.

DR. GEORGE R. STALTER has been appointed as medical officer in charge at the United States Veterans' Hospital, American Lake, Wash.

RUTH SWALESTIEN has accepted the superintendency of the Florence Crittenton Home, Los Angeles.

BLANCHE PFEFFERKORN has been appointed director of studies for the National League of Nursing Education. A committee of nursing educators from various parts of the United States will act in an advisory capacity to MISS PFEFFERKORN.

IRA J. DODGE, superintendent, Marietta Memorial Hospital, Marietta, Ohio, has been appointed superintendent, Huron Road Hospital, Cleveland, succeeding DR. SCOTT C. RUNNELLS. He will assume charge on May 1.

DR. HUGH S. CUMMING began on March 10 his fourth term as surgeon general of the United States Public Health Service.

JOHN R. HARDIN is the newly elected general chairman, Hospital Council of Essex County, New Jersey, which held its annual meeting recently at St. Michael's Hospital, Newark.

LELA J. MATTHEWS has been named superintendent, J. C. Hammond City Hospital, Geneseo, Ill.

SISTER MARY DE PAZZI is the new superintendent at Mercy Hospital, Chicago, succeeding SISTER VERONICA who is now superintendent of nurses, John B. Murphy Hospital, Chicago.

EDWARD GRONER has recently been appointed superintendent, Baptist Hospital, Alexandria, La.

JOSEPHINE B. O'CONNOR is the new superintendent, Clay County Hospital, Brazil, Ind.

CORA B. ANDERSON has become superintendent, Boll Memorial Hospital, Piqua, Ohio.

FLORENCE P. KATZ has been appointed business manager, Clark County Memorial Hospital, Jeffersonville, Ind.

H. G. FRITZ has recently accepted the superintendency of the Conemaugh Valley Memorial Hospital, Johnstown, Pa.

NELL CONNIFF is now superintendent, Riverside Hospital, Paducah, Ky.

JACOB BASS is now serving as executive director, Jewish Hospital of Brooklyn, Brooklyn, N. Y., having succeeded SAMUEL G. ASCHER who resigned.

MARY I. BOGARDUS is the newly appointed superintendent of nurses, University Clinics, University of Chicago. MISS BOGARDUS has been acting superintendent of nurses since August, 1931.

DR. J. H. HINES, Atlanta, Ga., has been chosen to serve as superintendent of medical service, Grady Hospital, Atlanta. DOCTOR HINES for a time was in charge of the United States Marine Hospital, Key West, Fla.

Well Known Denver Sanatorium to Close July 1

The Agnes Memorial Sanatorium, Denver, Colo., which has served tuberculous patients for thirty years, will close its doors on July 1. What new purpose the institution will be turned to has not yet been decided.

The rapidity with which tuberculosis is being eradicated is the primary reason for the closing of the sanatorium. The hospital, which has accommodations for 150 patients, is at present serving only forty-five.

DIETETICS AND INSTITUTIONAL FOOD SERVICE

Conducted by ANNA E. BOLLER, Central Free Dispensary at Rush Medical College, Chicago

Planning and Serving Two Hundred Thousand Meals a Month

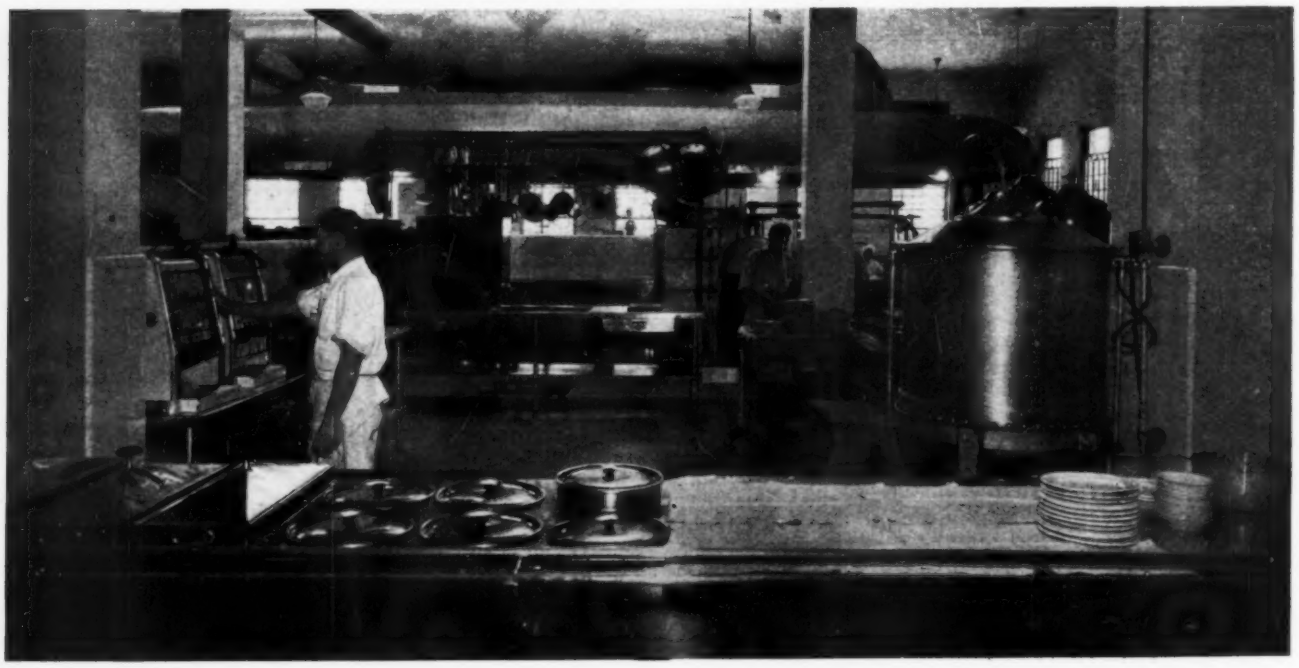
By KATHRYN A. McHENRY
Chief Dietitian, Edward Hines Jr. Hospital, Hines, Ill.

THE serving of diets, regular and special, to 1,700 patients in a general hospital, is not the wholesale procedure that one might at first suppose, as the organization of the dietetic department at the Edward Hines Jr. Hospital, Hines, Ill., described here, will show.

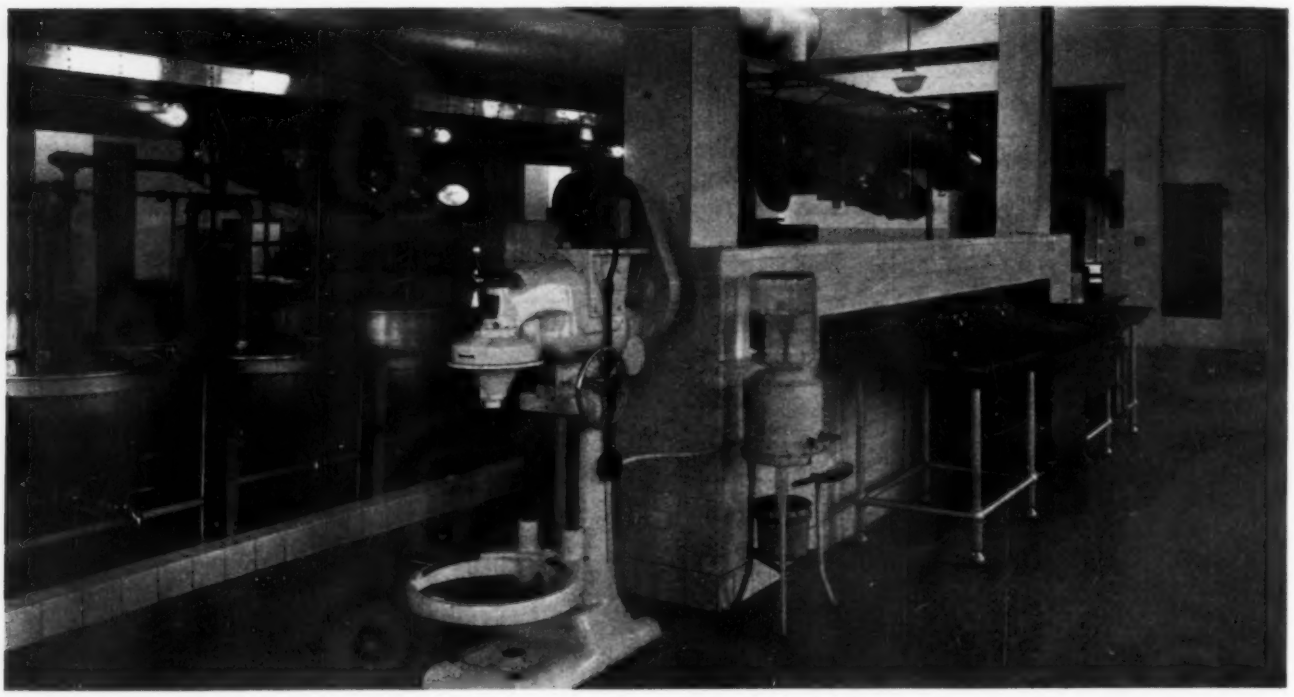
The following divisions together with their bed capacities exist at the hospital:

Tuberculosis section	A	243
Surgical section	B	370
Medical section	C and F	349
Reception service section	D	156
Cancer section	D and E	164
Diagnostic center section	E	101
Convalescent section	F	55
Neuropsychiatric section	G	287
Women's building	8	25
Total		1,750

One four-story building approximately half a mile long houses all of the sections, except the women's which is on the second floor of a two-



The large coffee urn pictured at the right is specially constructed, having no water urn, a filtering device on top and a water pump to circulate the coffee.



Metal sinks, electrical equipment and tiled walls and floors combine to make the kitchens both efficient and sanitary.

story building that has been equipped with dining rooms and a kitchen to serve the personnel. Twenty-six buildings supply space for the various activities of the medical center.

Four main kitchens, four special diet kitchens, ten dining rooms, four cafeterias, a bake shop, a butcher shop and storage refrigerators comprise the space allotted to the dietary department.

Each of the four units consisting of main kitchen, special diet kitchen, cafeteria, dining rooms, dishwashing room, refrigeration room and dietitians' office, might be likened to the dietary department of a large hospital. The smallest unit serves approximately 500 patients, and the largest, 800. Three of the units are on the fourth and top floor of the hospital building, between the sections served.

Kitchen or unit AB is equipped to serve approximately 500 patients. One main kitchen provides the food for the tuberculosis or A section, and surgical or B section.

Attached to the main kitchen on the A section side is a dining room serving 100 to 125 regular diets to the tuberculosis section, a small dining room serving 25 special diets to the same section, and a special diet kitchen. The special diet kitchen prepares short orders and approved variations from the regular menu for about 40 tuberculous bed patients, 35 special diet trays are set up and served from this kitchen, and 50 regular trays, making a total of 125. All food used from the regular menu is prepared in the main kitchen. Foods for special diets, such as nephritic, colitis and diabetic, are prepared in the special diet kitchen of CD unit.

A cafeteria serving 200 regular diets to ambulatory patients from the surgical section, and a daily average of 60 out-patients, adjoins AB kitchen on the B section side. All special diet trays for the surgical section are prepared and sent in electrically heated tray carts from the diet kitchen in CD unit. All food for bed patients on regular diets is sent in bulk to ward kitchens where the trays are set up and served.

A head dietitian is in charge of AB kitchen. She is assisted by two staff dietitians who contact patients, chart diets, and check trays and between-meal nourishments.

The second unit, known as CD kitchen, provides food for the medical section, reception service, diagnostic center and women's section. One main kitchen with diet kitchens attached, provides food for approximately 600 patients, 300 to 325 of whom are on special diets. A cafeteria serving 200 regular diets, a special diet dining room serving 120, another special diet dining room serving 30 metabolic diets, a small diet kitchen providing food for 50 metabolic diets, and another diet kitchen providing food for 250 to 275 special diets, are attached to the main kitchen, making up what is called the special diet center, since the greater number of special diets served in the hospital are concentrated in this section. Whenever possible, items appearing on the regular menu are used, or modified for special diets. The menus are made several days in advance allowing ample time for

Now there's a palatable way to include *Vitamin B_1* in children's diets

THE URGENT need for sufficient vitamin B_1 in the diet of every growing child has been acknowledged by physicians everywhere.

Yet, until recently, there has been no really palatable way to include extra quantities of this appetite-stimulating, growth-promoting factor.

Now, however, Ralston Wheat Cereal is enriched with extra quantities of vitamin B_1 by the addition of pure wheat embryo. This makes it easy to provide children with a liberal daily supply of vitamin B_1, in the healthful, delicious quick-cooking cereal.

With the new Ralston there need be no danger of instructions being misunderstood—none of the trouble or uncertainty of mixing or adding concentrates to other foods—no struggling to force the child to eat a new, unfamiliar food —*not even one cent of additional expense!*

May we send you a Research Report on the new Ralston Wheat Cereal—and a sample for testing? Simply write "Ralston" on one of your letterheads and mail it to us at the address below.

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Does the cereal you recommend pass this test? **Examine, in your hand, a little of the wheat cereal you recommend. If it is a complete cereal it will consist of *Brown* particles containing two important minerals, phosphorous and iron; *Yellow* particles containing vitamins A and E, and the appetite-stimulating vitamin B_1; *White* particles containing starch for warmth and energy. Over-refining or processing removes or destroys some of these health-building properties. To be sure you are recommending a complete cereal, look for the brown, yellow and white particles. *All three are in Ralston.***

all bulk food orders to be prepared for the main kitchen. About fourteen different special diet menus are regularly required for large numbers of patients.

A patients' instruction room is another feature of this unit. In addition to the usual instruction, food selection for the patient who must eat in restaurants is emphasized. Approximately 200 special diet trays are prepared, set up, and distributed from this section. These are sent to the various wards in electrically heated tray carts which are provided with a cold compartment for salads, ices, drinks and cold foods.

This section is supervised by two head dietitians. One assumes responsibility for the administrative work, including the supervision of forty-five employees and the preparation and serving of 300 regular diets. The other takes care of the special diet work, including diet writing, preparation and service, contacting of patients, charting of diets, instruction of patients, and receiving of ward surgeon's orders. Four staff dietitians are assigned to this section.

The EF kitchen provides food for from 750 to 800 patients from the cancer, convalescent, medical and neuropsychiatric sections, known as E, F and G. A cafeteria having a seating capacity of 400, a diet kitchen providing food for 200, and a dining room seating 70 cancer cases, are attached to the main kitchen.

A special diet cafeteria has been worked out serving 100 to 110 special diets. Waiters have been specially trained by a dietitian for this particular work. A dietitian checks each tray as it is served and records on the patient's chart, at least once weekly, the amount of food that has been consumed in one representative day. After the special diets have been served, 350 to 400 regular diet cases are accommodated in the same cafeteria. About 180 medical cases are served in this section, F being a medical section with a convalescent ward.

The special diet kitchen prepares food for 200 diets which are transported to wards in electrically heated tray carts. No ward kitchens for serving regular diets are provided in the medical or cancer sections, hence, approximately 75 regular trays are prepared and distributed from this unit. Bulk food for 100 to 125 regular diets is sent to the neurological section ward diet kitchens, three in number, for distribution to trays and to patients who are able to go only to the ward dining rooms.

This unit is supervised by a head dietitian who is assisted by three staff dietitians. The special diet menus which are written by a dietitian in CD unit, the special diet center, are used in EF kitchen, thus avoiding a duplication of work, and assuring the uniformity which is required throughout the hospital. No metabolic diets are prepared in this kitchen. Such cases are concentrated in the CD sections.

The personnel, 700 in number, are served from the fourth main kitchen, known as No. 8. This kitchen occupies the main floor of a small building attached to the hospital by a covered walk. A cafeteria serving 400 to 475 is provided for the employees. A dining room serving approximately 200 is provided for doctors, nurses and dietitians. One staff dietitian is assigned to this unit and has entire responsibility for personnel, food preparation and serving.

The women's ward with a bed capacity of twenty-five, is on the second floor of this building.

TYPICAL BUDGET FOR ONE QUARTER

Central Office Purchases	*Amount*	*Per Cent*
1. Warehouse		
a. Canned goods and groceries	$ 14,000.00	13.89
2. Drop Shipment	8,000.00	7.94
a. Flour, sugar		
b. Cereals		
c. Coffee, tea, cocoa, chocolate, fat and oil		
Field Purchases		
1. Packing House and Dairy Products (Meat, milk, butter eggs, ice cream and poultry)	64,845.00	64.33
2. Bread, Crackers	2,810.00	2.79
3. Fish	1,970.00	1.95
4. Groceries and Yeast	675.00	.67
5. Fruits and Vegetables	8,500.00	8.43
Total	$100,800.00	100.00

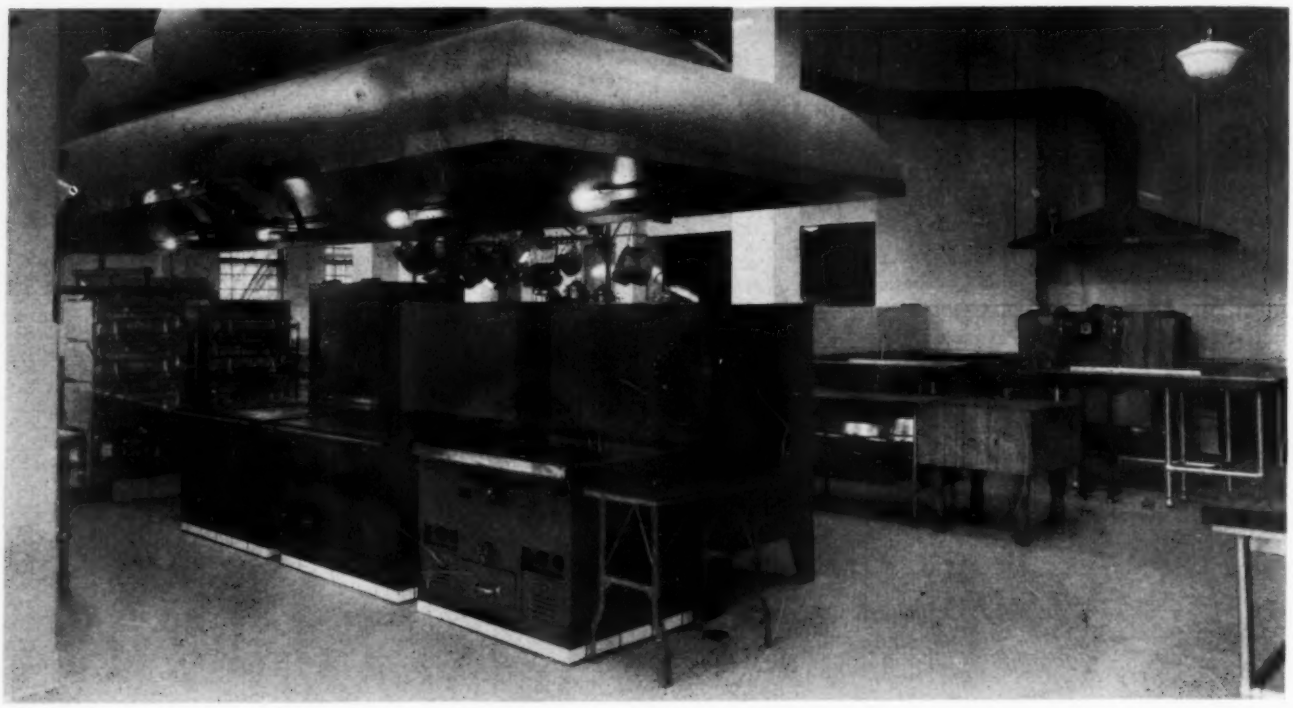
Regular diet trays, usually about 12 in number, are set up in the personnel kitchen and sent to the second floor by a dumb-waiter. Special diets are transported in electrically heated tray carts from the special diet center.

A uniform serving schedule prevails throughout the institution. Meals are served in patients' cafeterias and dining rooms as follows: breakfast at 7, dinner at 12, and supper at 5. Serving of special diet and regular trays is begun twenty minutes before the cafeterias and dining rooms are opened, and continues for from thirty to forty-five minutes.

Electricity, gas and steam have been used in equipping the four units. An interesting opportunity has been afforded to make use of different kinds of fuel and equipment. The advantages and disadvantages of each have been considered. The economy of operation, the length of time the equipment will serve, the satisfaction rendered during service and the appearance, all have been studied. Plain institution kitchens and dining rooms have been studied critically with an eye toward combining beauty with utility. The time has come when ugliness at least must give place to sightliness.

One kitchen is electrically equipped throughout with ranges, broilers, ovens, fryers, toasters, mixers and refrigerators. The coffee urn is a specially constructed piece of equipment, having no water urn, a filtering device on top and a water pump to circulate the coffee. This particular urn has proved efficient, and particularly economical of space, which is often limited. Nonrusting metal has been used throughout for dishwashers, tables, steam tables, sinks, and dish warmers.

The ventilating system is worthy of note. A large canopy, covering the ranges and other equipment, has been so placed that excellent ventilation is assured at all times. A signal light shows whether or not the fan is in operation. Good ventilation, plus windows on three sides, makes this a well ventilated, well lighted and pleasant place to work.



The canopy covering the ranges has been so placed that excellent ventilation is assured at all times.

The three other units on the fourth and top floor of the hospital are equipped with gas, steam and electricity. The ovens, broilers and ranges are fueled with gas. Part of the cooking is done in steamers, steam pots and steam roasters. Electric egg boilers, poachers, toasters, refrigerators and mixers are used. A number of the coffee urns already described are in use. Each kitchen is provided with an adjoining dishwashing room, or a dishwashing set-up in the main kitchen. When possible, a separate room has been built to avoid the noise and moisture dishwashing brings to a kitchen. In addition, dish sterilizers have been installed. Ample refrigeration and storage space has been provided in each unit.

The dietitian in charge of each unit is held responsible for the proper use, care and repair of utensils, dishes, silverware and dining room furniture. Once every three months an inventory of all property is taken, shortages and overages are

listed, and a statement of such is prepared for the supply officer. All broken articles must be listed and exchanged for new ones once each month.

Each of the four main kitchens has a chef, and cooks, waiters and kitchen helpers sufficient in number to take care of the patient or personnel load. Exclusive of twenty-two kitchen helpers assigned to ward diet kitchens where regular trays are served, from thirty-five to forty-five employees are needed in each unit. The kitchen employees are directly responsible to the chef. The dining room, cafeteria, and tray employees are directly responsible to the dietitian. The head dietitian in charge of each section has full authority over all employees from the chef down, and holds the chef responsible for the details of the work of the kitchen helpers.

How Kitchen Employees Are Hired

The personnel clerk of the institution cooperates in the hiring of kitchen employees, all of whom are interviewed and approved by the chief dietitian before they are hired. A specification exists for each of the approximately 200 positions in the department. This enables the dietitian and employee to know the duties that must be accomplished. Should a part of the work assigned to any employee become unnecessary, it is the dietitian's responsibility to rewrite the specification if sufficient work remains to warrant continuance of the position.

Food is procured by the central office in Washington, D. C., and by field or hospital purchase. The accompanying table indicates how this plan is carried out.

The average number of rations served in three months is 210,000 at a unit cost per ration of 48 cents. Four times yearly, a request is made by the chief dietitian to the budget officer for sufficient funds to supply the food needs of the entire institution for three months. The budget is planned and requisitions are sent to the central office, Washington, D. C., for warehouse and drop shipments. Estimates are sent to the procurement department of the hospital on which contracts are based for field purchases. Contracts for packing house and dairy products and fish are made to cover a period of two months. Required quantities of the various items are then ordered as needed. Weekly contracts are made on fresh fruits and vegetables.

Specifications on packing house and dairy products have been written and published in booklet form by the central office. Specifications on bread, crackers, fish, groceries, fruits and vegetables, are made at the hospital and modified as necessity or season may require. The groceries purchased at the hospital now consist chiefly of special diet foods such as fruits canned without sugar, vegetables canned without salt, and frozen orange juice.

A rigid inspection of all packing house products, butter and eggs, fresh fruits and vegetables is provided by the Bureau of Agricultural Economics to ensure proper quality. Milk, cream and ice cream are tested for fat content and bacteria count by the hospital laboratory. The dietetic department is responsible for the inspection of all foods upon their arrival at the station. The food is delivered to the subsistence building and placed in the custody of the supply officer until issued to the dietetic department.

The subsistence building houses the bakery, which supplies cakes, pastries, rolls, muffins, salt poor bread, and other needs for the institution. The butcher shop is also in this building. Carcasses of beef, lamb and veal are purchased whenever it is practical to do so. Beef is corned, and tongues are pickled. The bakery and butcher shop are under the supervision of the dietetic department.

This outlines the administrative problem of serving from 500 to 600 special diets, from 1,100 to 1,200 regular diets and meals for 700 members of the personnel, but the real heart of the situation consists of the 600 patients who require therapeutic diets. A staff of sixteen graduate dietitians is maintained to carry on the work of the department with its multiplicity of details, ranging from the economical expenditure of funds to the more vital problem of supplying the right foods to those in need of dietotherapy.

Administering the Department

The work of the four units is directed from the chief dietitian's office on the fourth floor at the center of the building. All matters of administration pertaining to the department pass through this office. The regular menu is prepared, special diet menus are checked, and all kitchen and ward orders are routed to the supply officer. The consolidated diet sheets or orders from the twenty-five wards of the hospital are assembled, recorded and distributed to the dietitians in charge of the kitchens. Orders and memorandums from the manager and clinical director are received and distributed to the units for the information of the personnel concerned. Transfers of employees from one unit to like positions in another are effected when the patient load rises or falls in a section, or when better management requires that a change be made. Whenever possible the work of the four kitchen units is administered as one.

HOSPITAL EQUIPMENT AND OPERATION

Conducted by C. W. MUNGER, M.D.
Director, Grasslands Hospital, Valhalla, N. Y.

Examining the Finer Structural Details of a Dutch Hospital

By M. A. VAN NIEUKERKEN
J. J., M. A., and J. van Nieukerken, Architects, The Hague, Holland

THE elimination of sounds in a modern hospital is a major problem. How this problem was solved in the building of the new Deaconess Home, The Hague, Holland, is discussed here in detail.

Since the situation of the hospital wing ensured perfect protection from outside noises and also from those emanating from other parts of the building, the main task was to soundproof the building against the noises created within the hospital itself, such as the resounding of the voice in the sickroom and the penetration of the sounds from adjoining rooms.

All outside walls are double, with an air space between the outer wall of hard and the inner wall of soft brick. The inner walls, varying in thickness from 44 to 22 centimeters, rest directly on the foundation. It may be noted here as an interesting fact that in old buildings with heavy walls, even in those equipped with modern piping, ducts and conduits, sound problems present themselves less frequently than in modern buildings in which an economical use of materials is sought.

Eliminating Sound Transmission

After a careful consideration of various floor constructions, reenforced concrete having a minimum thickness of 12 centimeters was chosen. To eliminate sound transmission from one floor to another, the ceilings of smoothly finished stucco were suspended 20 centimeters below the reenforced concrete floors by means of hangers, and the floors themselves covered with a layer of sawdust concrete 7 centimeters thick, four parts of cement to seven of sawdust. In the rooms this layer is covered with cork linoleum, 7 millimeters thick, and in the halls and corridors with rubber 5 millimeters thick.

Horizontal transmission of sound through the concrete floors themselves is prevented by a continuous strip of cork between adjoining floors where they meet at the supporting walls between corridors and sickrooms and at the partition walls between the latter. Where the floors are supported on the walls they rest on a layer of asphalt paper; similarly the reenforced concrete floor beams rest on a heavy layer of lead.

Building Is Divided Into Bays

To reduce sound transmission to a minimum along pipes and conduits, the following means have been adopted:

When the fact that all rooms on all floors are separated by walls rising directly from the foundations is taken into account, the building may be considered as being divided into bays. In accordance with this arrangement all piping for hot and cold water, for heating and for drainage and the cables and wires for power and light rise vertically in bay groups from the main piping and cable system in the basement. Radiators in rooms above one another are connected to one rising heater pipe, passing through ceilings and floors in large bushings stuffed with flax. Connections of any of these systems between rooms horizontally have been carefully avoided.

The washstands in the rooms of each bay are mounted against the corridor wall, all piping for these being arranged in niches in the corridors. In this way the shortest possible connections and a

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24-HOUR DUTY is demanded of a hospital floor. Year in and year out, hurrying feet and scouring brushes combine to wear it down—destroy its color and lustre—mar its surface.

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Johns-Manville Tile Flooring stands up under the abuse that quickly destroys ordinary floors. It actually thrives under heavy traffic. Floors laid 6 years ago, today look as well as when first put down.

Ordinary soap and water will keep this hygienic floor immaculately clean at the minimum of time and expense. Bacteria-breeding dirt cannot stick to its close-grained surface. J-M Tile Flooring is strictly sanitary. Ordinary chemicals do not stain it. It is impervious to burns and is not easily scarred by hospital apparatus. You do not have to wax or polish this floor to keep it looking attractive and bright. You save in first cost—you save in maintenance cost.

And yet this hard-wearing floor is not hard under foot. Its resiliency takes the click out of hard heels and hurrying footsteps—makes it comfortable under foot and above all, slip-safe.

• • •

Johns-Manville Tile Flooring in a variety of attractive designs and color combinations easily lends itself to any plan of interior decoration.

For wards or private rooms, corridors or basements, for every foot of hospital floor, use J-M Tile Flooring.

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Tile Flooring

TYPE A

total absence of piping inside the rooms are assured.

The electric wiring in each bay connects the switches and convenience outlets, arranged as frequently as possible at the patients' beds, directly with the junction boxes in the corridor.

Piping Is in Full View

Emphasis is laid here on the principle adopted throughout for all services, with the single exception of the electrical conduits, that all piping was to be arranged in full view. Although at first sight this might seem somewhat odd, the consideration that in case of repairs or changes, all noise, disturbance and dirt must be avoided in a hospital, regardless even of the savings in expenses, fully warrants the adoption of this principle.

To reduce the transmission of noises in the corridors to the rooms, the doors are constructed from a framework, covered on each side with a sheet of plywood, the space between being filled with a sound absorbent material. The door frames are arranged, however, for double doors; the second door can readily be hung if the patient should so desire.

Contributary to soundproofing, but mainly in order to avoid the aspect of bareness in a sickroom, all rooms are papered with a washable wall covering. Only the wards for eight and twelve patients and the children's wards have painted walls.

Except in the wards for twelve patients and in the aseptic and septic operating rooms, there are no double windows. The quiet surroundings made these unnecessary from a noise standpoint; from a ventilating viewpoint it proved, after thorough study, that double windows were undesirable rather than desirable, the difficulty usually being greater to maintain a comfortable fresh atmosphere in a sickroom than to raise the temperature. To ensure the entrance of plenty of daylight the window area of each sickroom is about one-third to one-fourth of the floor area. All windows open fully, top and bottom, thus creating the same effect as if the patients were lying in open loggias. The top sashes are horizontally hinged, the lower ones vertically. They can be locked in any position.

How Ventilation Is Obtained

The radiators in the sickrooms are mounted under the windows and are dimensioned to heat the rooms to a temperature of 20° C. (68° F.) with an outdoor temperature of –15° C. (5° F.).

The corridors in a hospital must, of course, be well heated. Frequently they are too hot, however, for the healthy persons who mostly use them and thus cause in the nurses a sense of fatigue and depression. Ventilation by the use of windows and avoidance of drafts at the same time may be considered out of the question. Since long corridors are apt to show draft phenomena, they are divided into short sections by means of draft doors at each wing and at the stairways. Continuous air renewal is ensured by providing, in each of these sections, a ventilating duct directly communicating with the outdoors.

The wards for twelve patients have windows on three sides. In addition to the possibility of admitting some fresh air under all wind directions, these three sides each have large bay windows separated from the room by glass partitions with horizontally hinged windows in them. The cove, thus formed, is heated with radiators, while openings in the low wall under its outside windows, provided with shutters, admit outside air. Preheated fresh air is thus available even with the most adverse weather conditions. During the summer these glass partitions are opened up entirely without leaving any obstacle for the entrance of direct outside air.

Both Coal and Oil Are Used

The two forementioned operating rooms have double windows. Between the two sets of windows are heavy heating coils. The outside windows have a number of small adjustable horizontally hinged windows at the bottom, the inside windows have a similar group much higher up, thus allowing any desired amount of preheated fresh air to enter these operating rooms. During the summer the lower vertically hinged sashes or the upper horizontally hinged sashes, or both, can be opened. After an operation these two rooms can be aired. All the windows in the rooms may be opened as well as those in the adioining washrooms. In addition, there is a ventilator, communicating indirectly with the outside, in the ceiling opposite the large windows.

Around the walls of the operating rooms, plate radiators of one plate thickness have been placed in order to obtain even heat distribution.

Between the two skylight windows of the aseptic operating room, heating coils are installed to counteract the heat losses through the glass roof.

Since steam was required for sterilizing and for kitchen purposes, three boilers of 75 square meters heating surface each were installed, two equipped with automatic stokers for coal, and the third oil fired, and practically noiseless.

A combination of coal and oil fired boilers was chosen to prevent definite commitment to one system. The mechanical stoker assured practically perfect combustion, even of the lowest priced solid fuels, making the operating costs at present less than with oil. Since during the summer months the operation of one boiler suffices, the use of the

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oil fired boiler releases the attendants for other work. Moreover, this boiler can readily be forced to meet the sudden demands in the morning for hot water throughout the building or after particularly cold nights when the temperature of the building has dropped inordinately.

Each boiler is connected with a counterflow hot water heater for the central heating system. The hot water is circulated under pressure by one or two pumps—dependent upon weather conditions—each rated at 25,000 liter per hour, and each figured for two-thirds the full capacity of the system. A third pump of the same capacity serves as a spare.

The hot water heating system is divided into two main groups, one for the hospital and operating department, and the other for the remainder of the building. Each main group is divided into the same number of vertical sections as there are bays. Each section or sub-group can be turned off or drained separately in the basement floor. Each vertical section has therefore a width of only about 3 meters.

As a matter of economy the fires under the boilers are banked during the night and the circulating pumps stopped except when it is extremely cold.

Providing for Auxiliary Heating

To enable the operating suite to be fully heated in the event of emergency operations during the night, without having to fire up the main boilers, an auxiliary heating installation is provided in the basement under the kitchen. This installation consists of two heavily insulated hot water heaters, each 4 cubic meters in volume, heated with special steam coils connected to the main steam supply. These heaters are mounted in a separate heating room. This heat storage plant is controlled with special thermostats from the operating rooms so that even after the operation is completed, an adequate heat supply is assured. Unless the temperature of the operating suite is permitted to fall below 10° C. (50° F.) this auxiliary heating plant will raise the temperature in the operating suite in forty minutes to 25° C. (77° F.) with an outside temperature of –15° C. (5° F.). In addition to the thermostat control, the operating nurse can set a time clock which sets the circulating pumps in action at any time desired. This auxiliary heating plant is equally readily available for the heating of the operating suite during cool days in spring and autumn.

To enable various clinics, examination and treatment rooms to be heated during especially cool days in summer without recourse to the main heating plant, small steam radiators have been installed, connected to the fresh steam supply which must be available in any event for the sterilizers in those rooms.

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tells "When the opening of a Hospital depended upon the loyalty of three men and a boy"

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The American line includes every supply item you need—proven, dependable merchandise at fair prices.

THE scheduled opening of this Hospital was only eight days away. Suddenly it was discovered that the ordering of a "hundred and one" supply items had been entirely overlooked—items that must be had **immediately. . . .**

An American Hospital Supply Corporation representative was called. He worked into the small hours of the night compiling the list of needed merchandise. . . . The order reached his company's offices Saturday morning marked **must be delivered within 96 hours** . . . and the three men and a boy went to work! All day Saturday and Sunday they assembled, checked and packed these hundreds of items—and the supplies were at the Hospital **on the dot.**

. . . Literally, the opening of this Hospital depended on the loyalty and feeling of responsibility of these "three men and boy"—employees of American who, without any "orders" from their managing executives, realized the seriousness of the situation and voluntarily met it.

This incident expresses a spirit of cooperation and dependability that you should consider carefully when selecting your source of supply. It means satisfaction all the time—some time it may be **invaluable** to you.

American Hospital Supply Corporation

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American Supplies and Equipment *are All Proven and Dependable*

The towel racks in bathrooms, ward kitchens, small children's rooms, utility rooms and examination rooms, are connected to the hot water supply and can thus be used as sources of heat outside the normal heating season.

In the kitchen and soiled clothes spaces, and in the sputa room of the children's department, liberal drying closets equipped with steam coils are built.

As a precaution against corrosion the boiler water is treated.

An Independent Water System

As in the case of the heating system, night service of the hot water system is eliminated by the installation of a large storage system. It consists of two storage tanks, each of 4 cubic meters capacity, in which the water is heated to 80° C. (176° F.) by removable steam coils, mounted in the control room. These heaters serve the entire building with the exception of the kitchen and the operating suite; two pumps, each rated at 5,000 liter, one a spare, are used to circulate the water through the system. Kitchen and operating suite are served from a similar but independent system, located with the auxiliary heating system under the kitchen. This independent system has a capacity of 2,000 liter and can furnish water at higher temperature if desired.

The city of The Hague, like several other communities situated within a reasonable distance of the North Sea coast, obtains its water from the sand dunes lining the coast. Although the water is fairly hard, it is excellent for drinking after it has been filtered. The same water is normally also used for utilitarian purposes.

Since rate concessions, even with the extremely high consumption of an institution as here described, were out of the question and the location at the foot of the dunes was favorable, it was found more economical to have a private water supply. A well was drilled about 55 meters deep and of 20,000-liter capacity. The water obtained is of practically the same quality as the city water before purification. After treatment it corresponds in all respects with the water from the municipal supply.

Cables and Conduits Are Variously Colored

The two electrically driven pumps, one a spare, and each of 8,000 liter per hour rating, force the water through three iron filters to a tank of 12,000-liter capacity, located 5 meters above the highest point of the building. In case of failure of the power supply to the motors, an extra pump driven by a gasoline engine is available. The water is carried from the tank to the various sections of the building by mains of about 12 centimeters diameter, located in the basement. At all times an ample supply of cold water is thus assured.

Cold and hot water pipes are widely separated throughout, in most cases with walls between them. The principal water main can be transferred to the municipal supply by one single connection. The fire hydrants around the entire building are permanently connected to the city mains. Pipes, conduits and cables for the various services are easily distinguishable throughout by their respective colors.

Electricity is obtained from the municipal electric supply. For the emergency lighting system a storage battery is available, feeding normally twenty-seven lights; it is fed by an 18-ampere, 180-volt converter installed in the switchboard room. The emergency lights are distributed over certain strategic locations such as in the operating rooms, a few of the clinics, in corridors and in the chapel. They fit in as a part of the regular lighting system, thus ensuring the charge and discharge of the battery and the observance of defects or burnouts in the emergency system.

Transmitting the Patients' Calls

A second storage battery, fed by its own converter, supplies the signal lamps in the sickrooms, the annunciators and call lamps, the bells in the Sisters' rooms, the buzzers and the clock circuit.

A soft buzzer in the patient's room, actuated by the signal circuit, reassures the patient that his call is transmitted; the calls are received in the corresponding ward kitchen both by buzzer and by signal light. In each patient's room is also an outlet for the connection of a small buzzer which each nurse in care of patients carries with her. This enables any nurse to call other nurses in adjoining rooms in case of emergency while she herself is unable to leave the patient in her charge.

The rooms in which the night calls are received have been equipped with a lightboard on which the nurses in charge, on night duty, can indicate in which section of the building they may be reached during their rounds.

Each patient's room has, in addition to its ordinary lighting, a green night lamp. Above the bed is a reading light and at the head one convenience outlet for light and one for power, the latter for special treatments.

The building is equipped with a special power circuit for motors of various sizes and to anticipate the possibility of electrically heating during the spring and autumn patients' private rooms and certain rooms in use by the administration.

A special circuit is available for x-ray treatment.

The telephone system, which is of the automatic type, is connected with the municipal network and is operated from a central board near the main entrance. With a few designated exceptions, all telephones can be interconnected. In the patients' rooms of the first and second-class, telephone out-

lets are available for those who desire this service and are permitted to have it. During the night, part of the service, more particularly that in the hospital service, can be switched over to a central board in the night waiting room.

The installation of radio connections was carefully considered but, in principle, the installation in a sickroom was deemed inadvisable. In consequence these connections were made only in the rooms of incurable and aged patients and in the drawing rooms of the nurses.

Treatment of Various Spaces

In the wards for from five to twelve patients and in the isolation rooms, the walls and ceilings are painted and the floors covered with rubber, 5 millimeters thick and of 70° hardness. In all other sickrooms the walls are covered with washable wallpaper to a height of 2.50 meters, the remaining part of the walls and the ceiling being painted. After fifteen to seventeen years' use in various hospitals and sanitariums and almost monthly washings with disinfectants, it has been found that the washable wallpaper stands up well and today is yet like new.

Built-in closets in the sickrooms have been avoided for sanitary reasons. After a patient has vacated a room all furniture is removed from it and thoroughly cleaned and washed in the loggias and balconies provided for that purpose.

All doors in the hospital and in the clinics and of rooms used by patients are finished absolutely flat.

In all operating rooms, clinics and examination rooms, walls and ceilings are plastered and polished in hard cement; the floors are of a granite composition with hollow upstanding plinths. The various bathrooms, sputa rooms, ward kitchens, service rooms and toilets are lined with tiles to a height of 1.70 meters and finished in white plaster above this. In these rooms the floors also are of a granite composition. To prevent cracks, these floors were laid in small alternate sections which were allowed to shrink before the intervening sections were laid.

The kitchen was tiled to its full height and the adjoining spaces to a height of 1.80 meters.

Providing a Cozy Homelike Atmosphere

The Sisters' drawing and dining rooms are wainscoted to a height of 2.50 meters and paneled, each panel space being covered with washable wallpaper. The floors of these rooms are of oak parquetry, laid in asphalt. The drawing rooms have large, open fireplaces. The nurses' rooms are papered to a height of 2.50 meters and smooth-plastered white above that, to be painted later.

Since they are very easily cleaned, the floors in the corridors of the nurses' home are covered with

a granite composition. Those in the hospital have a 5 millimeters thick rubber floor covering which is used for its sound absorption qualities.

All stairways are of fireproof construction with granite steps, iron railings and wood handrails.

The walls of the chapel are of finished brickwork with sandstone trim, the floors are covered with vitrified tiles laid in patterns, the main colors being red and black. The roof structure, in American yellow pine, waxed, is exposed; the vaulted roof of the choir section is also of finished brickwork. The choir section, which is wainscoted in oak, is raised 50 centimeters above the chapel floor; from it arises the pulpit flanked by a decorative oak railing.

Although all wainscoting and paneling were kept simple for sanitary and maintenance reasons, it does not create the feeling of austerity and coldness so common in modern buildings. On the contrary, an attempt was made to surround both the patients and the Sisters with an atmosphere of warmth, coziness and comfort which characterizes "home" in its highest sense, and the spirit underlying the Deaconesses' work.

A New Suture for Skin and Tension Work Is Perfected

A new suture for skin and tension work has been made noncapillary and flexible, and has a distinctive blue color that is stable, making the sutures readily discernible in the tissues. They are strong, resistant to tissue fluids, nonirritating, and uniform in size. Age, climate or light does not affect them, and they are sterilized by heat. The exteriors of the tubes may be sterilized by boiling or by any active germicidal solution. The sutures are prepared in a variety of sizes.

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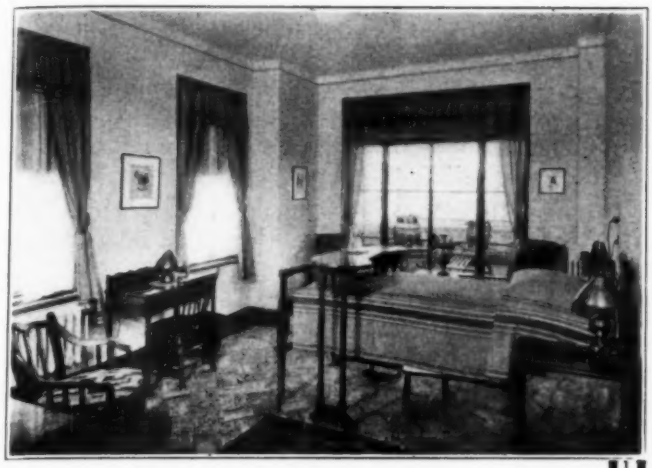
These tablets are rapidly and entirely soluble in hot or cold water, and because of this easy solubility they must be protected from moisture. They



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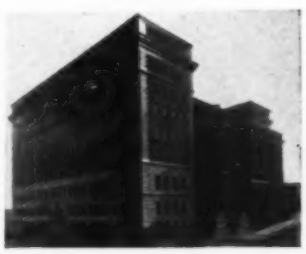

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